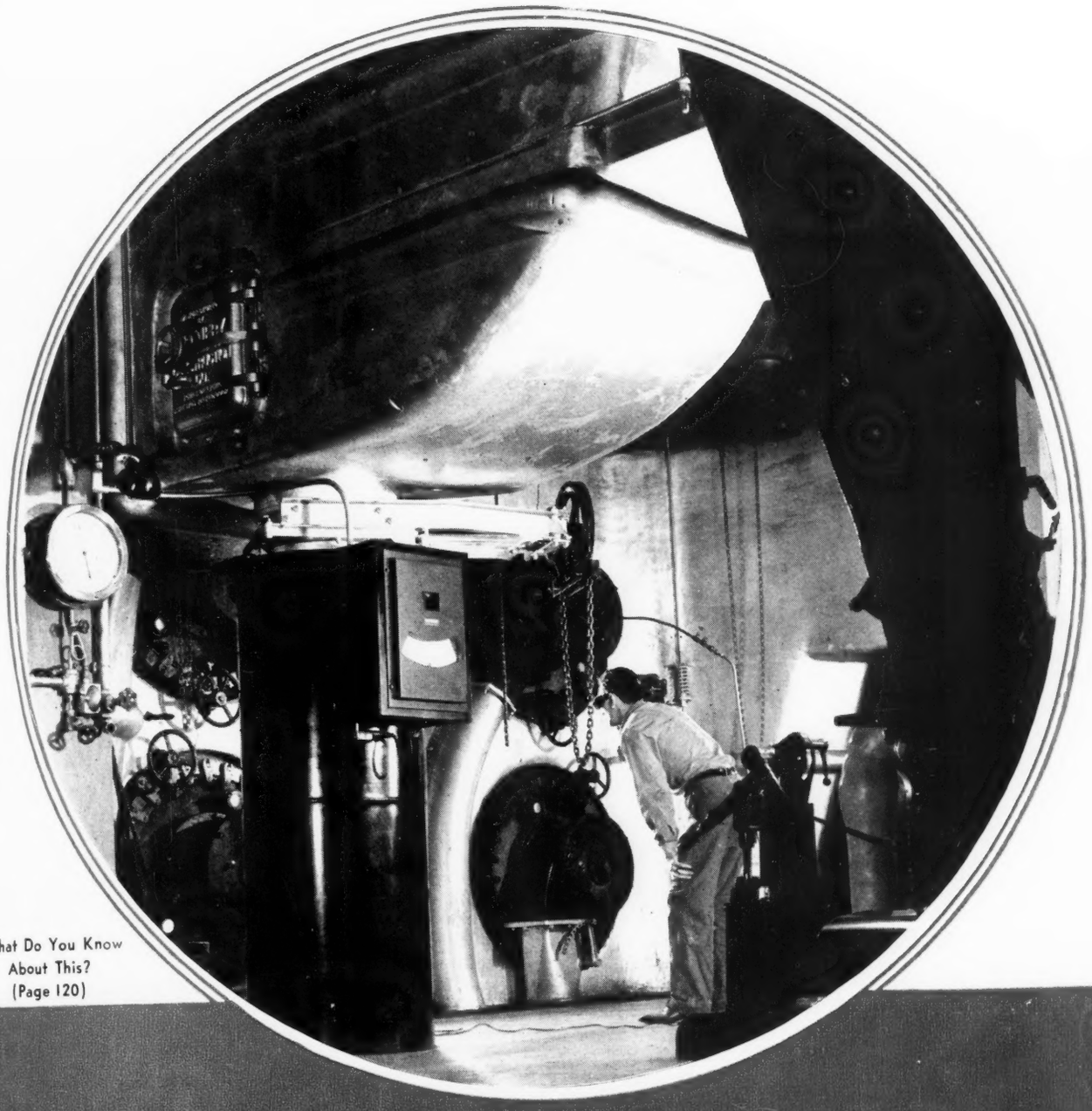

What Do You Know About This?
(Page 120)

the MODERN HOSPITAL

VOLUME 65 SEPTEMBER 1945 NUMBER 3

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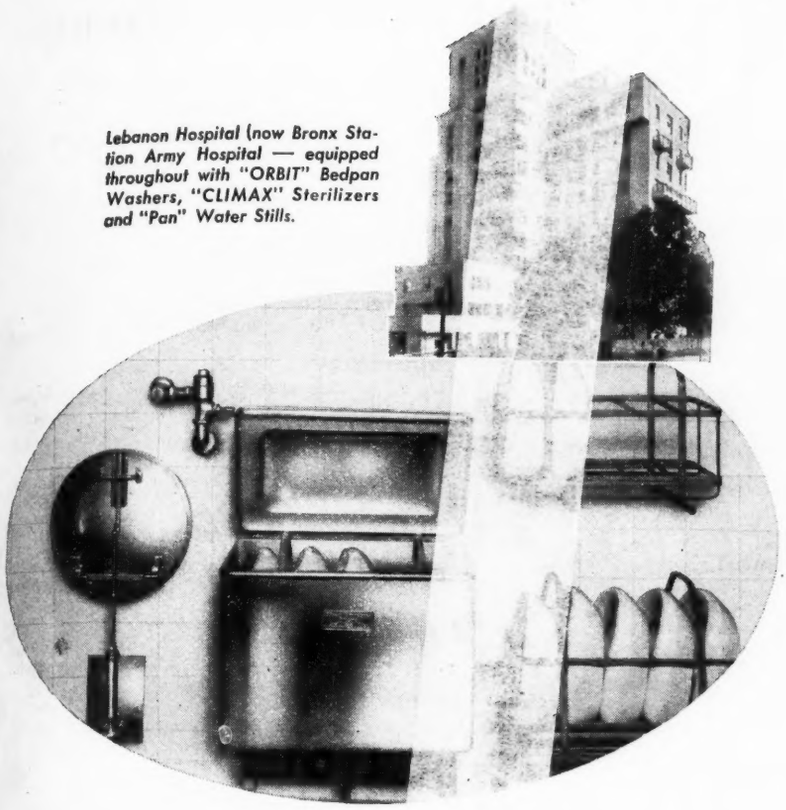

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Published monthly and copyrighted, 1945. The Modern Hospital Publishing Company, Inc., 919 North Michigan Avenue, Chicago 11. Otho F. Ball, president; Raymond P. Sloan, vice president; Everett W. Jones, vice president; Stanley R. Clague, secretary; James G. Jarrett, treasurer. North and South America, $3 a year; foreign, $4. Single copies: current, 35c; back, 50c to $1. Entered as second-class matter, Oct. 1, 1918, at the post office at Chicago, Ill., under act of March 3, 1879. Printed in U.S.A.

NEW IDEAS

Hospital Care at Home ★ *Helicopter Ambulances* ★ *"Ratings" for Nurses* ★ *Chemistry and Construction* ★ *Time and Motion Studies* ★ *Personal Service Bureau* ★ *Reconditioning for Civilians*

Hospital Care at Home

HAVEN EMERSON, M.D.
Visiting Professor in Public Health
University of Minnesota Medical School
Minneapolis

TWO benefits to patients and the public accrue from the increased use of general hospitals for diagnosis and treatment of disease. One is the development of group standards, discipline and supervisory control over the quality of professional services offered within the hospital through the organization and authority of the medical staff. The other is such command of equipment and related technical personnel for diagnosis and treatment of the sick as the individual physician cannot afford or direct.

These benefits are effective for bed patients and for out-patients who come on their feet or are brought to the hospital. Is there a need for extension of these benefits to serve persons whose homes are suitable for the care of the sickness from which they are suffering and for the diagnosis and treatment of whose disease the hospital's professional staff, equipment and services are either indispensable or at least notably superior to those available through the family physician in his individual capacity?

The visiting nurse who provides bedside care of the sick to carry out the orders of the attending physician and to report the patient's progress and needs to him carries into the home many of the skills of hospital ward service, of operating room and dietary kitchen and the purposes of aseptic technic. She conducts her professional life subject to the supervision, coordination and technical disciplines applied through the administrative and educational directors and general or specialist supervisors of the Visiting Nurse Association she serves.

Patients referred to the visiting nurse come in large numbers from general hospitals through the discharge office or, under ideal conditions, from the medical social service of the hospital. The latter has already become familiar with the economic, social, personality and other related problems of patient and family in the course of interpreting the physician's or surgeon's plan of treatment or the management of the patient to the family and has made known the limitations and resources of the home and household to the medical service concerned.

The nurse giving bedside care in the home on a per visit or hourly basis, with or without appointment as to day and hour of visit, can continue after a first visit only where there is a physician in charge who accepts medical responsibility and is recognized by patient, family and nurse as in authority. This attending physician may or may not be a member of a hospital or out-patient staff and may or may not, for this or other reasons, have access to hospital facilities of a laboratory character to confirm, supplement or control the diagnosis and subsequent course of the illness. His own resources in time and equipment and skills may not permit the performance of necessary tests except through some institutional resource, such as that of a hospital or public health laboratory.

Must the patients be moved to the hospital for the sake of getting the special skills to be had there when, in fact, the home is, except for this lack, a better place for certain patients to be?

The attending physician may through hospital courtesy obtain the laboratory services needed even though he is not a member of the

hospital staff. The patient may need laboratory or treatment procedures requiring a call at the hospital but not a bed or overnight stay in the hospital. For this, the hospital would expect the services to be on the order, or at least under the professional direction, of a member of the hospital staff.

The interests of economy, from community or family or patient point of view, are best met by having lodging and board of the patient provided by his home.

The interests of the best in diagnosis and medical care are served by maintaining the closest professional relationship between the attending physician and nurse and the hospital bed or out-patient service.

Where, as in small communities or rural or county situations, there is only one hospital to which all physicians have access and where the liberality of field nurse provision permits public health nursing and visiting or bedside nursing in the home to be under a single integrated organization, there is no necessary conflict of interest, and the professional program and quality of medical and nursing care may be as nearly as practicable the same whether the patient occupies a hospital bed or his own bedroom or porch.

However, in large cities, where there are several or many hospitals, where there are some or many physicians in private practice not connected with any hospital staff and where, as is common, there are hospital bed patients and out-patients and private physician's patients who cannot pay for their care in sickness, there is usually no way other than admission to the hospital by which many of these patients can receive good care. This may be necessary solely because bedside or visiting nursing or, more commonly, medical attendance cannot be arranged for at home, and yet the home may be suitable for both the patient and his disease or disability.

The citizens of the community, as voluntary contributors or as taxpayers and as potential future or actual past patients, have built and supported the hospitals. The medical staff usually represents the best medical brains and highest level of professional discipline in the community. Hospital bed care is the most costly of all the various units or components of organized care of the sick, *i.e.* by institutions and agencies through the associated services of many persons assembled to do a particular job. It is socially, professionally and economically accepted that good medical care is an obligation that must be met for persons of a wide variety of social and economic levels and for those unable to meet the cost, as well as for others.

Is not the time ripe, is not the organization available, is not the object quite clear and definite for development of the resources of our general hospitals through an extern staff to care for economically eligible patients in their homes with the assistance of visiting nurses, either of an independent existing organization or as members of the hospital nursing staff trained for bedside nursing in the home?

Objection to extension of such extramural, hospital-directed medical and nursing care in patients' homes will probably be voiced by an occasional physician who sees in this an economic threat to his livelihood. A consideration for the best medical care to the public need not be a cause

Discussion From the Floor

JOSEPH G. NORBY
Administrator
Columbia Hospital, Milwaukee

DOCTOR EMERSON'S article is intriguing reading for several reasons. It poses an interesting development in hospital activity and it indicates, it seems to me, a reversal of philosophy on the part of the writer who, I had understood from previous expressions, was opposed to the hospital's expanding its activities beyond the walls of the institution itself and considered public health activities as being solely the function of another agency.

Those of us who have felt that the hospital has a broad function to perform in the public health field are greatly encouraged by support from so eminent an authority as Doctor Emerson.

The suggestion that hospital facilities and services be extended to the home presents an ideal devoutly to be desired, but it seems to me that it presents both difficulties and contradictions of purpose. Home patients being scattered widely over a community pose a problem in service that would be costly and would be uneconomical beyond certain limits. Such a system would not make fully available to the patient the concentration of equipment and the "associated services of many persons assembled to do certain specific jobs."

The results of one laboratory test frequently suggest another or a series. Therapeutic applications may be suggested through consultations available in the hospital and therapeutic agents may be obtained there that are not easily available in the home.

Out-patient service is available to ambulatory patients without bed assignment, but when bed care is necessary it still seems that the hospital is indicated, even for the shorter stays necessary for the performance of diagnostic or therapeutic studies.

E. M. BLUESTONE, M.D.
Director
Montefiore Hospital, New York City

THE old pendulum is swinging back again in its figurative way and we are beginning to look longingly at our homes as we search for more and more hospital beds. Postwar planning is a good exercise in administrative skill but we shall find ourselves over-bedded in our hospitals if it is carried out to the last detail and home care is excluded.

We have already drawn attention in these columns to the acute character of the chronic problem and the need for providing a Department for Continued Care in the general hospital to look after this neglected group of patients. We shall have enough hospital beds for everyone if we use them intelligently and take advantage of the extramural possibilities furnished by a patient who is subsidized in his own home under hospital supervision.

Patients seek or are referred to hospitals for one or more reasons. The

of diminished opportunity to the practicing physician. Patients unable to pay for medical care are a proper public charge whether the physician is independently in practice or is an intern, resident or member of the hospital staff. Graduates of the hospital or former interns serving a particular neighborhood of the community can be attached to the extern staff for purposes of home care.

The nursing service can be done by affiliation with an existing autonomous visiting nurse service association of the community, or the hospital nursing organization can be extended to include visiting nurses responsible to the hospital nursing department.

Professional responsibility for such home medical care would presumably rest with a full-time salaried director of the extramural service, a position similar to that of the director of an out-patient service, such a director being responsible administratively to the hospital administrator and professionally to the medical board or executive committee of the staff.

Such a service could begin in a small way with nonpaying, so-called indigent or medically indigent public charge patients whose illnesses require medical and nursing attendance but not hospital bed care. These would include postoperative surgical patients, inoperable cancer patients, some cardiac and arthritic patients, many neurological and psychiatric patients, and often diabetics. These and similar types of patients in households not incompatible with gentle and humane care could remain at home and yet continue to have the guidance, protection and skills best obtained from a hospital organization without the necessity of making the community pay the hospital costs of their shelter and food, as well as provide for doctoring and nursing.

Many of the social and economic catastrophies of illness follow or result from the break-up of a home unit by removal of one member to the hospital when the presence of that one person is perhaps indispensable to family morale and maintenance.

We have so long emphasized the benefits resulting to patient and family from removal of the sick one to the hospital that we have forgotten the reciprocal or contrary situation of sickness best cared for at home, or at least as well cared for and at less cost.

Now that medical practice to an increasing degree is becoming concentrated for office and bed patients within the walls of the general hospital where staff members not only attend bed and dispensary patients but have their own offices, it seems reasonable to plan for the further development of the hospital plant, organization, equipment and medical staff standards and discipline for that residual but still considerable fraction of patients who need hospital technics, technicians and professional service benefits without at the same time becoming boarders or hotel guests under the hospital roof.

Any general hospital can with but a few months' period of inquiry convince its trustees and medical staff that an appreciable percentage of patients admitted to hospital care would not have needed to be so admitted if the hospital had been in a position to take to the home by the extern and the visiting nurse the services indispensable to good medical care.

clinical problem is often of such a character that the scientific facilities of the hospital are required for its management. A typical example is the need for a major surgical operation. Often, too, the patient cannot afford the services of medical science in his own home and must therefore go to a hospital, where he becomes a member of a highly concentrated group that is cared for by a converging number of physicians, surgeons and specialists with instruments of precision at their disposal. In other words, the social aspects of medical care are often strongly decisive in the problem of hospitalization.

Hospital care is usually the most expensive type of medical care to either the patient, the taxpayer or the philanthropist. Home care, under hospital supervision, is less than half as expensive in typical cases. If the patient can be cared for safely and successfully in his own home, under hospital supervision and subsidy (providing necessary medical, nursing, social service and auxiliary service visits) a hospital bed is released for more intensive use. Home care can often be provided in this manner for any type —the short-term, the long-term, the custodial and the convalescent—thus adding extramural beds to the hospital which could only be provided otherwise at considerable expense.

Hospital care should be reserved for short-term and long-term patients who need intensive medical care of this kind which they cannot be given at home. In carefully selected cases home care should be provided in order to make such an allocation of hospital beds possible.

BASIL C. MacLEAN, M.D.
Director
Strong Memorial Hospital
Rochester, N. Y.

THE provision of comprehensive medical and nursing service in the hospital, home and out-patient department by the staffs of general hospitals has been presented by Doctor Emerson as a device to ensure continuity of medical care of good quality. His plan differs in no important respect from group practice, except that at the outset the out-patient and home service would be limited to indigent and near indigent patients. Perhaps this is as it should be, because under present conditions the paying patient, whether or not enrolled with a medical group, receives the services of staff members of a hospital at home in the office or in the hospital.

Other writers have dealt with this subject and the recent monograph by Jensen, Weiskotten and Thomas ("Medical Care of the Discharged Hospital Patient," the Commonwealth Fund, New York, 1944) describes a practical approach to the problem.

Although Doctor Emerson properly emphasizes the benefits to be obtained from visiting nurse care in the home, it may be that he unduly stresses the advantages of home care as compared with hospital care. It is true that many patients would prefer to be cared for at home and would do very well there if assured good medical and nursing service. It is true also that visiting nurse service should be closely integrated with hospital service and nursing service. However, it is equally true that removal from the worries and cares of the home may be as conducive to recovery and convalescence

as the scientific aids that the hospital environment furnishes.

The question of cost is not satisfactorily answered. Doctor Emerson supposes a saving in bed and board costs of hospital care, which make up slightly more than half of the usual hospital bill. This saving will be canceled to a considerable extent by the fact that the individual or community must make provision for bed and board at home and that the travel and expenditure of time incidental to physicians' visits in the home and the provision of diagnostic tests for the patient in the home entail a considerable increase over the cost of the same services in the hospital. There is no doubt, however, that more satisfactory provision for home care will relieve the unprecedented demand on hospitalization.

With these reservations in mind, the proposal deserves experimentation in a small way by a number of hospitals to provide home care for postoperative surgical patients, cardiacs, arthritics and similar types of patients requiring ordinary care.

HERMAN SMITH, M.D.
Administrator
Michael Reese Hospital
Chicago

DOCTOR EMERSON presents an interesting and persuasive thesis regarding the extension of hospital service into the home. As he points out, home nursing service is an accepted entity, particularly through visiting nurse associations. In communities where home nursing is contemplated as a new service it should, as Doctor Emerson infers, only be considered as a joint operation and on the basis of a visiting nurse program.

The extension of medical service into the home is not quite as clear cut as the nursing program. As Doctor Emerson points out, it is probably only to be considered, if at all, in larger urban communities. In smaller communities physicians can be depended upon to care for their patients without hospitalization, if this is the indicated procedure, and surely will care for the discharged hospital patient as soon as he leaves the hospital.

In larger cities the problem is more complicated because of the existence of a set pattern of private practice by many practitioners who are not connected with the ward services of a hospital, and in this whole discussion Doctor Emerson, I am sure, is discussing the ward rather than the private patient.

In one instance a small group of family welfare organizations in Chicago has worked out a program with a general hospital whereby home visiting is done for the clients of these agencies by a physician of the hospital clinic staff who is paid by the family agency. Whenever necessary, these patients are given complete workups in the clinic by all the specialists of the clinic but are cared for in their homes by the visiting physicians, as much as possible. The service is a most valuable one. The patient gets better service and many hospital days are saved. The same program takes effect upon discharge when this clinic physician assumes responsibility as soon as the patient can possibly leave the hospital, even for a convalescent home.

In another instance in the same hospital, a fund has been established for the payment, on a visitation basis, of a younger clinic physician for the home visiting of chronic cardiacs who are clinic patients unable to come to the clinic as frequently as is necessary for proper followup. Without the services of this physician many of these patients would have to be cared for in the hospital in order to be given adequate and proper treatment.

For specialized work of this type there is no question that home medical care is highly desirable. To institute a general program in a large urban community requires basic planning and is not without expense. Physicians of a community who are in the habit of sending their patients to a particular hospital could, by a series of formal and informal postgraduate courses, be made completely familiar with a hospital's and its staff's procedures. Many patients could be kept under the care of these private physicians in their homes by the hospital's setting up a consultation service of certain of its staff men for the home visiting of these patients who would have been determined by all concerned to be on a ward rather than a private patient level.

This type of program would be ideal because the private practitioner would keep in contact with his patients, he would be given the satisfaction of doing the type of philanthropy that all physicians desire to do and he would have the opportunity of consultation with more experienced staff physicians to be sure that his program was sound. More important would be the educational value involved in the medical development of practitioners in a community. Interns could be assigned to this consultation service with great benefit to their practical education.

Doctor Emerson has pointed out a real possibility which may, on detailed development, not only save hospital days but, even more important, develop a larger corps of better qualified physicians.

Helicopter

R. D. BRISBANE

IN PLANNING that new hospital have you made provision for a helicopter ambulance airfield? Especially for the hospitals serving large rural areas or the city research or medical center, an adjacent helicopter field is a "must" for the immediate postwar future.

For the immediate vicinity of the city hospital within 2 or 3 miles, undoubtedly the automobile ambulance still will be the best means of transportation of the ill or injured; but when the saturation point of traffic is reached on our present narrow, outmoded streets, points in the suburbs 5 or more miles from the emergency wards will be far more accessible by the newly developed helicopter that can land in a space not much larger than its own shadow, pick up the injured and be at the hospital in but a fraction of time needed for the ordinary ambulance to thread crowded arteries.

Little Landing Space Needed

Small parks, vacant lots, flat tops of large buildings, parking areas for automobiles, or even the less used streets can serve as emergency landing fields for the helicopter on its mission of mercy within corporate limits. In the rural districts, within a radius of 200 miles, or later much farther, this type of ambulance transportation will prove unequaled. In parts of the West or South where 300 or more days of flying weather prevail annually, conditions should prove ideal for rapid and widespread development of the helicopter ambulance.

Conventional planes of even the Cub or Moth types require an airstrip 1000 feet long with unobstructed clearances at either end, proper markings and lighting facilities if they are to be used at night. If larger planes are used to transport the sick, landings must be made at

Ambulance

Manager
Sutter General and
Maternity Hospitals
Sacramento, Calif.

At a demonstration at Wright Field, Ohio, a helicopter equipped as an ambulance plane lands in an area whose terrain prohibits the use of an airplane. The "wounded" man is being placed on a stretcher preparatory to being placed in the litter capsule on the helicopter. Photograph by Air Technical Service Command.

municipal ports far outside the city with consequent transfer to an automobile ambulance and another journey through crowded streets and possible fatal delay, not to speak of the expense.

The helicopter can overcome all these disadvantages with door-to-door conveyance. For the case requiring an operation within hours, a telephone call to the hospital would bring a helicopter and a roundtrip air run of even 200 miles can easily be accomplished within two hours without as much danger or inconvenience to the patients as in an automobile. In tests already made as a flying ambulance, the helicopter has passed every qualification, "the occupant reporting he was quite

Can Transport Plasma, Medicines

As another adjunct for the future hospital, the helicopter can be used for transporting plasma or hospital personnel to the immediate scene of isolated accidents where minutes may mean lives. When a Navy destroyer exploded off the New Jersey Coast Dec. 31, 1943, it was a helicopter that picked up the plasma from the tiny lawn of Battery Park and in a few minutes landed *beside the wounded* on the beach. No other means of transportation could have reached them so quickly.

To mountainous glaciers or passes, along lonely beaches, on isolated islands of our larger lakes and rivers, to mining camps, sawmill sites in our forests, no matter how bad the roads and in weather prohibitive to the conventional airplane, the helicopter will bring the doctor, the nurse or life-saving drugs to the sick, the wounded and the injured, or it will settle down in a clearing beside them and bear them quickly to the shelter of a modern hospital. comfortable and without objectionable drafts, vibrations or noises."

With the development of the "walkie-talkie" and short-wave radio communication during the war, peace time will immediately provide constant two-way communication from the hospital to air ambulance so that hospital management may know the exact location of the ambulance at all times or make any necessary preparations for care of the injured upon arrival. It is not too early for larger hospitals to ask for wave length allocations for this very purpose. Automobile ambulances also should be equipped for the same short-wave controls. Lives as well as valuable time will be saved when the hospital can reroute a returning ambulance to pick up other sick or injured.

There has been much discussion in the past few years concerning the poor distribution of hospital facilities, especially for the more thinly settled areas of the country. I foresee in the near future a time when the helicopter can bring the sick of every type directly to the doors of a centralized hospital from a radius of 500 miles if necessary. This will mean, in turn, that the duplication of expense and personnel in our present inadequate hospital facilities will be obviated and, instead, progressive medical centers can be established at strategic points in such neglected areas where complete diagnostic departments and every aid to medical science can be concentrated for the use of highly trained doctors and nurses.

I do not mean that the smaller hospitals have failed to do all that is humanly possible for their communities, but that sufficient financial support cannot be found in these rural areas to provide the necessary equipment and better personnel according to present standards.

In addition to the small area needed for landing one or more air ambulances of this type within the hospital grounds, the future hospital must arrange for space for private helicopters of physicians and surgeons. Before the war, many doctors in the West owned and operated their own planes between smaller towns with their cow pasture airfields and the urban hospitals but suffered the usual delay in transferring to a taxi at the airport and getting into town through traffic.

The hospital of 1950 that provides for these progressive air-minded medicos not only will be building its own reputation and patronage but will fulfill its destiny as a medical center where the younger doctors can find a complete armamentarium sufficient to all their needs and to which they can bring their patients with every confidence.

Another thought for the hospital planner is the possibility of placing his institution in the suburbs on

spacious acres of cheap land where there will be every advantage for future construction of any type a hundred years hence and where there will be all the ground necessary for the convenience of every mode of transportation.

Within the next decade many of our metropolitan hospitals now in the heart of their patronage will find themselves on the fringes of, or even totally isolated in, shabby and slum-like surroundings because of the rapid movement of population to more healthful suburbs or even to the country or hills miles distant from offices and workshops.

Away from the city streets and the lofty towers of multistoried hospitals with their huge expense of construction and overhead that eventually is all passed on to the sick or the taxpayers, the horizontal type of building will prevail. It can easily be constructed and just as easily discarded in another quarter century when newer materials and better methods have been developed that will make 1945 just as antiquated as 1900 appears to us. And on the greensward and among flowers and trees, the sick can find the peace of mind and healing of their bodies "far from the crowd's ignoble strife."

As taxes and possible inflation take larger shares of the wage-earner's dollar, cheaper accommodations must be rapidly expanded if we are to give the masses adequate hospitalization within their means. If state medicine prevails costs will have to come down below the level of many hospitals or state and federal governments will be obliged to build at the taxpayer's expense. Cheaper exteriors, with better equipped interiors, located on cheaper suburban land, will be the longest steps toward hospitalization within the reach of all. Fast automobile and air transportation of the sick will bring the patronage.

All this may seem chimerical but when we read that the Army and Navy have for years conducted experiments with the rotary wing type of craft that has fulfilled a large share of their expectations, and that hard-headed management of large common carriers already has earmarked millions of dollars for early manufacture of the helicopter as a feeder to bus and express lines and that some of the larger postoffices have plans for picking up mail from outlying airfields and bringing it by helicopter to downtown buildings, surely it is not too early for hospital management to lift its eyes to greater horizons for better and more expeditious care of the public by every means within its power.

May I commend as required reading of every hospital planner the exceptionally informative book by Col. M. F. Gregory recently published under the title, "Anything a Horse Can Do," or "The Story of the Helicopter."

Discussion From the Floor

HARVEY AGNEW, M.D.
Secretary
Canadian Medical Association
Toronto, Ont.

THE use of the helicopter as an aerial ambulance is a development which can well be anticipated. It proved its value a year or two ago when an airman crashed near Buffalo and the field ambulance could not get through the snowblocked sideroads. For more than a quarter of a century the Australia Island Mission has routinely used ordinary airplanes to serve the medical needs of the rural areas and in this country (Canada) patients regularly come down this way from the far north.

A helicopter would greatly simplify the landing and take-off problem, especially at either coast where fog and low ceilings so frequently paralyze flying. Mr. Brisbane's article is timely.

The question is: To what extent will patients, doctors and others travel to hospital by helicopter? The helicopter, being a slow speed machine, will not be likely to supplant the ordinary plane for long hops. It might be used, however, from the airport to the hospital roof or grounds and for reasonable distances as Mr. Brisbane suggests. The more responsible authorities in the helicopter field have warned us, too, that the helicopter will be a long time becoming as popular and ubiquitous as some journalists prophesy. Repeated improvements, for instance, will prevent any extensive drop in price.

However, the helicopter or its successor would seem to be here to stay and hospitals should plan accordingly. This means either landing space on the hospital grounds or on the roof; a district landing lot a few blocks away would have limited value for patients because of the necessity of rehandling by ambulance.

I would anticipate the first extensive use of the helicopter ambulance in rural and isolated areas, either by private operation or through governmental or other agency; it might then be extended to large centers in foggy or mountainous areas. Its general use in large cities has much to commend it and will develop, but I doubt that it will supplant the surface ambulance for routine service for many years.

W. S. RANKIN, M.D.
Director
Hospital and Orphans' Section
Duke Endowment, Charlotte, N. C.

MY FIRST reaction to the article on the helicopter ambulance was critical. Why should we be indulging in the discussion of a matter as remote as a helicopter ambulance when all hospitals are faced with so many more urgent and immediate problems? However, on reading the article, the emphasis is upon the helicopter ambulance *in its relation to the location and site of the hospital*, and the consideration of the location and site of a hospital is always and essentially a consideration of foresight. A great authority on highway construction once said to me: "The only permanent thing about a highway is its location." The highway wears out, is repaired and reconstructed, but if a mistake is made in locating the highway, all has to be discarded.

That observation has been of great assistance to me in advising communities with respect to suitable locations for their hospitals. Equipment wears out and is replaced. Buildings are repaired, rearranged, reconstructed and ultimately replaced, but the site is permanent and if the site is badly chosen without the wisdom of foresight then the fundamental mistake has been made.

So in the location of hospitals it is important that we keep in mind (a) the future and rapid growth of the hospital itself; (b) proper space for the nurses' home and its future additions; (c) space for recreational facilities for hospital personnel; (d) space for the parking of employes' cars, doctors' cars and visitors' cars, and (e) space for the helicopter ambulance of the future. And, if the helicopter doesn't need the space, we may be sure that the hospital will find some other real need for it.

"Ratings" for Nurses

P. J. McMILLIN
Superintendent
Baltimore City Hospitals
Baltimore

MOST people in both the hospital and nursing fields now agree that there is a place for the "practical nurse," more recently called "vocational nurse," and even more recently called "medical technician" by the Wacs.

What seems even more important is the fact that the same people admit that there will continue to be a place for this group, even after the existing war emergency has passed. Although there are many reasons on which these beliefs could be justified, I shall not at this point attempt to justify them. I am simply assuming they are correct. If they are correct, then there is some cause for concern.

Practical Nurse Not "Accepted"

My experience for twenty-five years has been with two hospitals, the first having an excellent three year school for graduate nurses, and the present one having an excellent one year school for practical nurses. The latter school was started in 1940, when it was apparent that a shortage of nurses was developing. In my experience with both groups, there has been evidence that among the rank and file graduates from the three year schools have not accepted graduates from schools with a shorter course.

The registered nurses have apparently felt that here was an untrained group coming into the field, where it would be doing things for which it was not qualified. The latter, of course, coveted the recognition which had always been given the graduate nurse, including the cap and school emblem. The practical nurse also looked with envy upon the organizations of the graduate nurse.

Growing out of all these things, perhaps in self-defense, has come the National Association for Practical Nurse Education. This organization for the practical nurse is set up in such way that it just about parallels the organization for graduate nurses which has been in existence for so long. With each group represented by a separate organization, it is not only possible, but entirely probable, that there will continue to be lack of understanding and acceptance of one another on the part of both groups. It would seem that to allow such a situation to develop would be most unfortunate.

Is it necessary? Is there some plan which might bring all nurses together, into one organization, whether they come from a five, a three or a one year school? Perhaps the type of schools in which nurses are taught, or the manner of teaching in these schools, may be responsible for the lack of sympathy. Some change in the fundamentals of these schools might be indicated. Perhaps an examination of the methods used so successfully by the military services during this war for training young men might point the way.

As are so many of our sons, mine is in the service. On entering, he chose the Navy and was accepted. Following "boot" training, during which certain intelligence, adaptability and other tests were made, he was assigned to a school for quartermasters.

In this school, after some theory and a certain amount of practical experience under supervision, he passed an examination and became a quartermaster, third class. Following some additional theory and another period of supervised practical experience, he passed a second examination. As a result, he was still a quartermaster, but with a second class rating. He then had his advanced theory and a longer period of more intensive supervised practical experience, after which he passed an examination. He still remained a quartermaster, but with a first class rating.

The boy is now in the group from which will be selected from time to time men to go on to the instructing and supervising positions through advanced schools. Had he failed in any one of the three examinations, he would have remained in that same class and would have been usable only in a position calling for a quartermaster of that particular class.

Would it be so unreasonable to think of teaching nurses in a school of similar type? This school would admit young women interested in becoming nurses, even though they came from various levels when measured in terms of formal education. Then, during a probation period, by means of certain intelligence and adaptability tests, those who apparently would not be capable of adjustment to nursing or of absorbing the necessary information would be eliminated.

The remaining students would be carried by proper instruction to a rating of nurse, third class, then second class and then first class, depending upon each individual's ability to progress through instruction and examination. It might well be that only two classes would be necessary to cover the field, but the principle would remain the same. Finally, the school would provide advanced instruction so that nurses, first class, might be carried on and be qualified for instructing and supervising positions.

Economy of Nursing Power

If such a plan could be developed, it would mean an economy of nursing power because nurses in the several classes would be used only for those nursing procedures for which they were fitted. The doctors, for example, in calling for a nurse to care for a private patient, would call a third, second or first class nurse, dependent upon the condition of the patient and the procedures that would be necessary in order to give that patient adequate and satisfactory care. Likewise, the hospitals

would use nurses, third, second and first class, each carrying the responsibilities for which she is qualified.

It would seem that such a plan as outlined would have many advantages. What would be more important than all, however, would be the fact that all persons engaged in nursing would be nurses. Each nurse would automatically fall within her proper classification, based entirely upon her ability to progress through the various classes. All would have the opportunity to graduate from class to class, when and as the necessary promotional examinations might be satisfactorily passed.

This plan might, at first, be considered as revolutionary. There is much evidence, however, pointing toward material and radical changes in educational programs and plans resulting from the experience gained through the education and training of millions of men in the military services during the war.

Should there be merit in some such plan as is here briefly outlined, and changes in such direction were made, it would, of course, also require certain changes in state legislation. It would seem entirely proper that the state boards of examiners in the various states should assume the responsibility for conducting the promotional examinations and supervising the progress of individuals from class to class.

Acceptance of such a plan would also automatically make necessary only one nursing organization extending from the national to the local level. This result alone would tend to eliminate the conflict between the present graduate nurse and the practical nurse and would wipe out all reason for the suspicion with which one group regards the other at the present time.

This plan, of course, is not offered as a finished product. It is offered, however, as having perhaps included some principles that might very well be studied by those interested in teaching young women the profession of nursing and providing nurses in such numbers as are required for the care of *all types* of patients, both in and out of hospitals and during either peace or war. The fact that this objective has not even been approached under the existing plan may be adequate reason to consider seriously the need for changing that plan radically.

Discussion From the Floor

GERTRUDE R. FOLENDORF, R.N.
Superintendent
Shriners' Hospitals for Crippled Children
San Francisco

MR. McMILLIN'S article implies that registered nurses have failed in their obligation to the public with relation to the "practical nurse." Nursing leaders recognized their responsibilities long ago and have been sympathetic toward women employed in this field.

It has been obvious that they need guidance from those more experienced in nursing and it has generally been accepted by registered nurses that licensing laws should be enacted and regulated by state boards of nurse examiners. That the National Association of Practical Nurse Education is represented on the national nursing planning committee for postwar adjustments in nursing is evidence that registered nurses are interested and are endeavoring to establish a dignified place in society for the practical nurse.

The rating of nurses as suggested would create more confusion than now exists. Nor would it be practicable to attempt preparation of these various groups in schools of nursing.

The desire to be a Good Samaritan does not qualify an applicant for entrance to an accredited nursing school.

Today's patient and the doctor expect something more than kindly intent. Both are demanding that nurses know why, as well as how, things should be done. They want skill based on careful, scientific, constructive study and only the persons with broad educational and cultural background will be able to adjust to the responsibilities that nursing involves.

If the practical nurse qualifies for admission to a school of nursing and desires to enroll there will be no question about her acceptance.

ELIZABETH W. ODELL, R.N.
Director of Nurses
Evanston Hospital, Evanston, Ill.

MR. McMILLIN'S article should stimulate thought and discussion, some of it controversial but, let us hope, open-minded. There is no doubt that experiments born of necessity for providing nursing care for the civilian population during the war have amply demonstrated that many plans could be effected which we had hitherto thought unworkable. Most notable of these is the training of Red Cross volunteer nurse's aides to perform routine nursing procedures under the supervision of a graduate nurse.

The members of this group of educated women have been the first to recognize the limitations of their own preparation for nursing and some of them have entered schools of nursing in order to obtain the basic preparation of which they feel the lack.

The school for nurses that Mr. McMillin envisions, based on the methods used in the training of Navy personnel, seems to me to present the following obstacles:

1. To admit young women to a school of nursing with little reference to educational qualifications seems to me to be a step backward and to be wasteful of time, money and human material. Experience has shown that young women of superior education prefer to enter a school with high admission standards.

2. Although many schools of nursing are far from being on the professional level required to keep step with modern medical practice, we should think in terms of a professional school offering a sound scientific preparation without which advancement is seriously handicapped. It is my understanding that the professional members of the Navy, for example, doctors, do not receive the same type of training as do enlisted men.

The trend in professional schools today is to eliminate unqualified applicants by careful selection, based on aptitude tests, educational and other qualifications before the student is admitted. The National League of Nursing Education nursing aptitude tests are proving to be of great value in the selection of candidates.

The feeling of antagonism between the graduate and practical nurse has, I believe, emanated partly from economic reasons, but mostly from the lack of proper legislation and regulation of preparation, duties and remuneration of the practical nurse group. In Detroit, the Community Nursing Bureau, which is approved by the District Nurses' Association and the Council on Community Nursing, places both graduate and practical nurses with no friction whatever. Organizations such as the Detroit Community Nursing Council point the way to a better understanding among all health and welfare groups.

Chemistry and Construction

A. J. HOCKETT, M.D.
Director
King County Hospital System
Seattle

WHILE, undoubtedly, autoclaves, thermometers and bedpans will continue to be necessities in every hospital in the postwar period, the impact of the advances of medical science during the last decade will influence hospital planning for many years to come. Hospital planning tends to fall into a routine which occasionally does not take full advantage of the progress being made in its own field.

It may be of interest to note some of the problems which have arisen in one particular area involving a considerable postwar expansion program, inasmuch as these problems are probably applicable to our postwar thinking in terms of new construction. In a conference with leaders in the medical and building professions, a discussion of the advances of medical science as applied to hospital planning brought out the following points:

1. **Surgery.** The lessons learned in the war will greatly increase the use of blood, plasma and related products in the immediate years to come. It is probable that it will be necessary to establish a plasma or serology center adjacent to the surgical department for the purpose of providing a convenient supply of these products day and night. Such a center should house all intravenous therapy and be manned by persons trained in this particular work; it should function as a separate unit of the hospital much as central supply has functioned in the past.

From the administrator's standpoint such a department should be planned on the drawing board from two points of view: first on the basis of standard architectural drawing and, second, from the standpoint of the actual functioning of each unit of the department and the placement of actual personnel with specified duties and spaces so that the department can function efficiently.

2. **Internal Medicine.** It has been found that the advent of the sulfa drugs and penicillin, when analyzed on the basis of patient-days, has markedly decreased hospitalization time for a large number of patients. A breakdown of the census on acute medical wards emphasizes this trend. Hospitals that have wards or rooms for the care of a large number of acutely ill patients will be able to accommodate many more patients suffering from diseases that are susceptible to these drugs than has heretofore been possible.

The advent of thiouracil in the treatment of goiter will influence hospital planning in the goiter belts. Its use will probably increase the incidence of hospitalization and, certainly, will require some expansion of metabolic departments in hospitals located in these areas.

The constantly expanding use of intravenous fluids and plasma would seem to indicate the necessity of complete bedside equipment for every room and ward bed for the convenient use of these medications.

The widespread use and misuse of vitamin products, which already constitutes a financial burden to hospitals and patients who pay the bills, has led me to believe that the dietary department of every hospital should be provided with personnel and equipment to evaluate patients' diets on the basis of vitamin, as well as caloric, content. I visualize a special diet kitchen, such as most hospitals now support, equipped to fill prescriptions for vitamin content without resort to the pharmacy, except for advanced or problem cases.

The problem of tuberculosis is the problem of the special hospital. It has been dramatically proved that tuberculosis is one of the diseases that can be wiped off the face of the earth. Proper facilities and substantial financing are practically all that are required to achieve such a result. Expenditures for the control of tuberculosis, from the standpoint of hospital facilities, should be directed toward the eventual abolition of such facilities.

3. **Orthopedics.** Most of the problems associated with the care of child patients have already been transferred to special hospitals. The problem of adult orthopedic cases has undergone great changes since the era of the Whitman cast, long hospitalization and long convalescence. With the development of the Roger

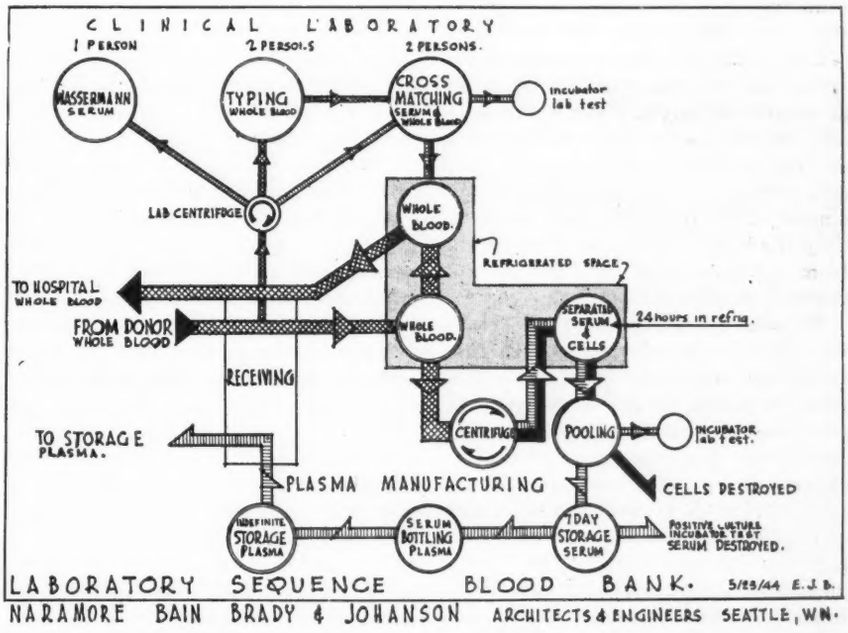


Diagram of the functions of a modern blood bank.

Anderson and other technics of pinning and the use of nonelectrolytic metals, hospitalization for orthopedic cases has been markedly reduced. An orthopedic fracture unit of 1930 with a 50 bed complement can easily be reduced in 1945 to a complement of 20 beds and still care for the same number of patients during any given period.

4. **Urology.** Changes in this specialty from the administrative standpoint have to do primarily with the development of transurethral resection. This procedure has progressed during the last fifteen years and has reduced hospitalization time considerably for these patients. However, most urological departments have noted an increase in patient days owing to the fact that more patients are living to advanced age, and in total numbers the problem has changed little from past years. Every hospital should make adequate provision for handling these patients.

It is not necessary that any elaborate provisions be made for the treatment of acute venereal diseases at the present time, chiefly because the advent of penicillin and sulfa drugs has removed the great majority of these patients to the out-patient clinic. By the same token, however, the planning of out-patient clinics should include appropriate facilities for the care of patients with venereal diseases.

5. **Neuropsychiatry.** The development of shock therapy has almost completely changed our concept of hospitalization for psychiatric patients. A therapy center of this type should be an important part of the plan of tomorrow's hospital. It is the feeling of many medical men that the treatment of neuropsychiatric patients in the future will be as much a function of the general hospital as the treatment of appendicitis has been in the past. Proper planning and provision for these patients, who will constitute a considerable part of the hospital census, should be considered in all hospital thinking.

The problem of morale in neuropsychiatric patients has caught the attention of many students of this subject. It is not beyond the realm of possibility that all general hospitals will have facilities for occupational therapy and physical therapy and even beauty parlors incorporated into their plans. The care and treatment of psychiatric patients constitute one of the great challenges to medicine and one to which every administrator should be alert.

6. **Geriatrics.** Probably the greatest changes in hospital planning have to do with this field. The progress of medical science is throwing not hundreds or thousands but literally millions of people into the age group in which the principal diseases are those of senescence and decline. During the last decade these patients have been classified as uninteresting cases or not eligible for hospital care. In the future it will be important that hospitals consider their proper responsibilities as centers for the care and rehabilitation of these patients.

The day of the home for incurables is past. The day of the rehabilitation center is dawning. In addition to careful medical supervision, all too often lacking in the past, hospitals must plan for greatly increased facilities for occupational therapy, which is the key to the care of these people.

A longshoreman who has outlived his vocation may quite easily be shunted to a bed as an invalid for the rest of his life. With proper application of occupational therapy methods it is perfectly possible to develop in the same person an entirely new attitude toward a new occupation which will convert him from a chronic invalid to a self-supporting and useful citizen.

The requirements are planning, personnel and understanding of the problems involved. The convalescent pavilion or rehabilitation unit should be a part of every hospital that is attempting to do its full job for its community.

Many important specialties have been omitted because the developments have not as yet proved of great importance as far as actual hospital planning and construction are concerned. It is entirely possible that further progress may constitute a challenge to our thinking which should not be overlooked in the years that lie ahead.

Discussion From the Floor

FRED G. CARTER, M.D.
Superintendent
St. Luke's Hospital
Cleveland

DOCTOR HOCKETT'S article on "Medical Progress and Hospital Planning" is both timely and interesting. The last decade has witnessed many advances in medical service to which the hospital must be adjusted as rapidly as circumstances will permit. In discussing his presentation I can only enlarge a bit upon his general theme by citing additional examples of progress that must come to keep the hospital abreast of the times from the managerial, as well as the medical, standpoint.

We must recognize the ever-increasing complexities of surgery. In this connection more and more emphasis must be placed on the importance of good anesthesia, which involves wide knowledge of physiological processes, expert choice of anesthetic agents, keen clinical judgment and adequate equipment and facilities. Among the last the "recovery suite" or "post-anesthesia suite" might be mentioned. Immediate postoperative care should be in the hands of those who have intimate knowledge of such matters and who have no other duties to distract their attention.

In the modern hospital in connection with the operating suite there will be fully equipped recovery wards where postoperative patients may be looked after for periods of from two to eight hours by specially trained nurses before they are returned to their rooms or wards for routine care. Doctor Hockett has mentioned the possibility of associating the blood bank with the surgical department. Perhaps in the training of medical anesthetists in the future they should be prepared to take complete charge of the operating suite with all of its rapidly increasing complications.

The war has emphasized the importance of logistics, getting the right thing or person to the right place at the right time with the least amount of effort. The hospital of the future should pay more attention to its traffic problems, assigning locations to departments with due consideration for the kind and amount of traffic involved.

Time and Motion Study

LILLIAN M. GILBRETH
Personnel Consultant, Montclair, N. J.

SINCE the very beginning of time and motion study, hospital problems have been closely associated with it. During his early days in the construction business Frank Gilbreth had a friend who was going through his internship and through him became tremendously interested in problems of hospital administration, in technics of management and in all the activities that go on in a hospital. Naturally, the most fascinating of these were in the area of surgery and in the work of the surgeon and all those who assisted him in the operating room. Several accidents at this time gave him firsthand experience as an observer which he utilized to the full.

Later as he developed the technics both of micromotion study and of the cyclegraph method of recording the tasks of motions, he had the needs of the hospital in mind, and the publications of the time and since that time, both in the hospital field and in that of industrial management, take account of the applications of these technics in the hospital field.

Since that time those who have been carrying on the development of time and motion study or work simplification have added to and adapted the technics until it would now seem time for the hospital group itself to take over the entire project of the utilization of available material in this field, to evaluate what has been done, to estimate what needs to be done and to utilize to the full the cooperation that is available from all of us who are working in the time and motion study field.

Of the material that is available for review and evaluation, much concerns itself directly with hospital problems. Groups of doctors, nurses, hospital administrators, hospital personnel people, those in charge of dietetics, of laundry and of other areas of hospital work have invited management men and specialists in time and motion study to speak at their meetings and in many cases have discussed the papers intelligently and comprehensively and have followed the meetings with applications of principles and technics to their own problems or with projects which have been carefully carried through.

In many cases material that might be of great and immediate use in hospitals is in the management literature but not in the hospital vocabulary. The underlying principles of time and motion study are applicable in the hospital field as in all other fields, but it is for the hospital man rather than the time and motion man to make it clear how many of these are directly applicable in the hospital field and how many must be adapted for use there.

Through the years we have been accustomed to having every person who becomes interested in time and motion study and the possibility of its application to his work start by saying, "But of course my work is different." When such a person sees *similarity* in his work to work in other areas we have made a good start, and review and evaluation can take place. We usually establish these likenesses through the old questions: What is being done? Who does it? Where? When? How? Why? These would certainly apply to all fields. It is through attempts to answer these questions that organization charts, functional charts, job analyses, personality analyses and all

Discussion From the Floor

JAMES A. HAMILTON
New Haven Hospital, New Haven Conn.

HOSPITALS have increased the total amount of their pay rolls in spite of a decreasing number of personnel. In the postwar period, if they reemploy up to the before-the-war numbers, they will be faced with a staggering total pay roll. No administrator is desirous of lowering the *rates* of pay, and external forces in the postwar period might not permit it.

Therefore, administrators are confronted with the necessity of rearranging the functions of positions in such a way as to: (1) permit the substitution of a larger portion of less skilled, and thus lower paid, workers and (2) replace human effort through the introduction of equipment and assisting mechanical apparatus. To do this intelligently and effectively requires a thorough analysis of each job, the development of new standards, work simplification and thus much time and motion study effort.

Mrs. Gilbreth is correct that there is much available material in the field of time and motion study already developed awaiting adaptation to the hospital field. Moreover, she is right to stress that the initiative for such adaptation and use must rest with the hospital administrator.

I heartily agree when she emphasizes that the adaptation of this material to our field demands as prerequisites (1) ". . . there must be some agreement as to results wanted and as to willingness to try to bring them about," and the ". . . study man must know exactly what the result is to be before he can work out the most economical and satisfying way of getting that result" and (2) that the remainder of the organization must be functioning well or else there will be "serious and discouraging delays" and the results will be fruitless.

the devices of management for collecting necessary information get under way.

Somewhere along the line and usually near the beginning it becomes evident that interest and attitudes are important and that there must be some agreement as to results wanted and as to willingness to try to bring them about. This ensured, we may check on the management setup and begin to plan the changes that need to be made.

Time and motion studies have often been found effective means for arousing interest, changing attitudes and helping bring about a willingness to review, to evaluate and to make changes. "Before and after" pictures, interesting case material on the applications of time and motion study and the results may make an individual or a group feel "We want this!"

On the other hand, introduction of time and motion study without a checkup on the effectiveness of management almost inevitably leads to delays and may lead to great discouragement. The time and motion study man must know exactly what the result is to be before he can work out the most economical and satisfying way of getting that result.

Human relations must be right before we can get that cooperation which is indispensable if he is to do his work. Anything from inadequate purchasing to inadequate accounting can hold up the work and often lack of provision for training or retraining may mean serious and discouraging delays in making the profits which the results warrant.

The standard text in this field is "Motion and Time Study" by Prof. Ralph M. Barnes of the University of Iowa, published by John Wiley & Sons and supplemented by books and work manuals by Professor Barnes, Prof. David Porter of New York University, Prof. Marvin Mundel of Purdue, Allan Mogensen and others working in this field. There is also valuable material in many of the management books which do not concern themselves exclusively with time and motion study.

The accumulated case material and new developments appear in *Factory Management and Maintenance,* edited by L. C. Morrow, and in other similar publications of the various management groups. But nothing can take the place of actual training in this field! Industry has profited tremendously by the training courses given under the auspices of the Training Within Industry groups and an excellent start in this field can be made in a job methods training course. These courses were designed primarily for men and women going into industry, but an adaptation has been made for nurses and now would seem to be an appropriate time for every group concerned with hospital work to request suitable adaptations to meet its needs.

During the war period E.S.M.W.T. (Engineering, Science, Management War Training) furnished a more expanded and intensive training in the time and motion field for industrial workers. The courses were, under the enabling act, available only to such workers, but undoubtedly the material in them can be adapted for hospital use. Those who have prepared the workbook, the films and other illustrative material are eager and willing to cooperate in such adaptation.

There has been no attempt in this article to present the recent developments in the time and motion field. This is simply a statement of a belief that all that is needed to service the hospital area completely is now available and that it is for those in that area to investigate, to evaluate and to use what is freely offered.

Personal Service Bureau

J. R. McGIBONY, M.D.
Hospital Facilities Section
U. S. Public Health Service
Washington, D. C.

ASK the average person for his outstanding impressions during a stay in the hospital and the chances are there will be a voluble and, perhaps, boringly lengthy description of a favorite physician or nurse, details of tests, examinations, flowers, cold food or predawn temperature taking, of the number of stitches, of noises and odors, of hard beds and enemas, of a hundred other personally vital subjects parading row on row sufficient to make Irvin Cobb's "Speaking of Operations" into a five foot shelf of books.

As the interest in these matters among family and friends dwindles, the former patient is no longer able to remember the details of those days in which the whole world appeared to revolve around his comfort and welfare. Only major impressions remain, distorted or emphasized by time and retelling. Back in the home routine there is increased appreciation of the little things—of personal habits and preferences, of being able to do things for one's self—and questions often arise, usually unexpressed, as to why someone had not thought to do this or that to contribute to the patient's comfort and peace of mind.

Then let a friend or relative be hospitalized and these little things are likely to be forgotten in the excitement or worry.

To provide the answers to these questions, perhaps hospitals should arrange for attention to these personal needs. Like a hotel, the hospital, to be successful, must sell service. In any hotel room will be found in an inconspicuous place, usually under the glass top of the desk or dresser, an attractive card enumerating special services available, barber or beauty shops, drugstore, rail or plane reservations, guides, dining facilities, public stenographer, florist, laundry and valet services. From that, perhaps, hospitals might glean an idea to add a personal touch to the cold efficiency that is often considered the acme of successful administration. In addition to supplying diagnostic and treatment facilities, the hospital, too, can be, to purloin a trite hotel phrase, "a home away from home."

Even to suggest added services to-

day when most hospital administrators are tearing their hair in almost futile efforts to obtain sufficient personnel to maintain even essential services may well be likened to proffering a drink to a drowning man, but it must be remembered that all wars come to an end. With the ultimate easing of the manpower shortage the progressive administrator will be the one who is ready to put into action ideas that will mark his institution as having kept ahead of the times.

To name a few of the services that would be welcome to many patients and their families, one of the first would be a personal shopping service. How many patients are hurried off to the hospital without opportunity to obtain additional needed pajamas, gowns, bedjackets, slippers, robes, tooth brushes, cosmetics or toilet articles? And often the family or friends may be absent, or too distraught or too busy to attend to such details. Or it may not be convenient for them to purchase these items or perhaps a toy for the little patient. A personal shopping service as part of a hospital service bureau could perform this function profitably by making a small service charge or through discounts for purchases from reliable dealers.

Another important item for patients, particularly when clothing for bed wear is not furnished by the hospital, is that of personal laundry. Most patients would appreciate expert laundering of gowns, jackets and pajamas during hospitalization since the supply of the average person is insufficient for prolonged stay without such service. From twenty-four to forty-eight hour service with reliable hand laundering of women's apparel would be welcome.

While newspapers are usually available, not all hospitals have libraries for the use of patients. The service bureau could maintain a rental library or arrange for such service through an establishment already in the neighborhood. Orders for new books, magazines, games and other amusement could be handled.

Flowers are an ever-present part of being hospitalized. Relatives and friends could be saved the inconveniencing details of searching for shops or might welcome an opportunity to place daily or regular orders. Profit to the hospital might accrue through an agreement with the florist to keep reception rooms, offices and other public places supplied with flowers. Such a pleasant note adds greatly to the impression the public forms of the institution.

Stenographic services, writing letters and notes of greeting or appreciation are services desired by many convalescent patients. Paying of outside bills and insurance premiums, bank deposits or cashing of checks are among business services which patients not infrequently need and for which they would gladly pay a service charge.

An important factor in the hospitalization of many a mother is the problem of the children left at home. It would be a tremendous relief if the service bureau could provide access to individuals or an agency that furnished reliable child care in her own home during her absence. Such care or assistance is often needed also after her return home. Too often, neither the mother nor her family is familiar with registries of nurses, practical nurses, nurse's aides, maids and others listed by employment agencies. Many a harried husband would welcome arrangements for cleaning and restoring a semblance of order in the maidless home to which his wife is returning after an absence in the hospital.

A bureau of personal service operated efficiently under the sponsorship of the hospital should more than pay its own way and provide a livelihood for enterprising individuals and at the same time permit the progressive hospital to render the complete service that is so desirable for rapid convalescence unfettered by needless worries.

Discussion From the Floor

ANTHONY J. J. ROURKE, M.D.
Physician and Superintendent
Stanford University Hospitals
San Francisco

DOCTOR McGIBONY'S article, which might be entitled "How to Win Commendation and Influence Patients," comes as a timely warning to hospital administrators who have been occupied with furnishing absolute necessities to keep hospital beds available. The attitude, "Don't you know there's a war on?" must now change. Public relations and personal service should play a major rôle in the administration of a modern hospital.

Public relations and personal service must, of course, be well balanced. The shopping and stenographic service, personal laundry, child care, florist service and news service must go hand-in-hand with the assurance that the presence of the patient's physician on the staff is warranted; that the sterility of the instruments and dressings used in surgery can be depended upon; that the services of a trained radiologist and pathologist are available; that the nursing service is of a high standard, and that the resident staff men are graduates of grade A schools.

Doctor McGibony is to be congratulated upon his article and I am heartily in favor of a personal service bureau for hospitals that acts as a front for the highest possible grade of medical and hospital service and is supported by an administration that is consciously aware of the need to find a way to distribute the cost more adequately.

JOSEPH TURNER, M.D.
Director
Mount Sinai Hospital, New York City

DOCTOR McGIBONY'S plea for a personal service of this sort is unexceptionable. I think most leading hospitals provide it in one form or another, although they may not identify it as a personal service or even recognize it as such.

Many of the hospitals known to me provide for it on their ward services through the social service department and in their private patient services through a receptionist. In this hospital we have two. They may be called on for any personal service. Shopping for patients has become easier in recent years through the extraordinary development of hospital shops.

There is little doubt that the possibilities of service in this field will increase, especially in crowded urban areas where the number of rooms for family living become fewer, making it more and more necessary to think of the hospital in terms of an "extra sickroom" which for many years was generally to be found in most homes.

All hospital executives, in arranging for personal service of this nature, must, in the last analysis, be guided by local needs and conditions.

Reconditioning for Civilians

MAJ. HENRY B. GWYNN, M.C.
Reconditioning Consultants Division
Office of the Surgeon General
Washington, D. C.

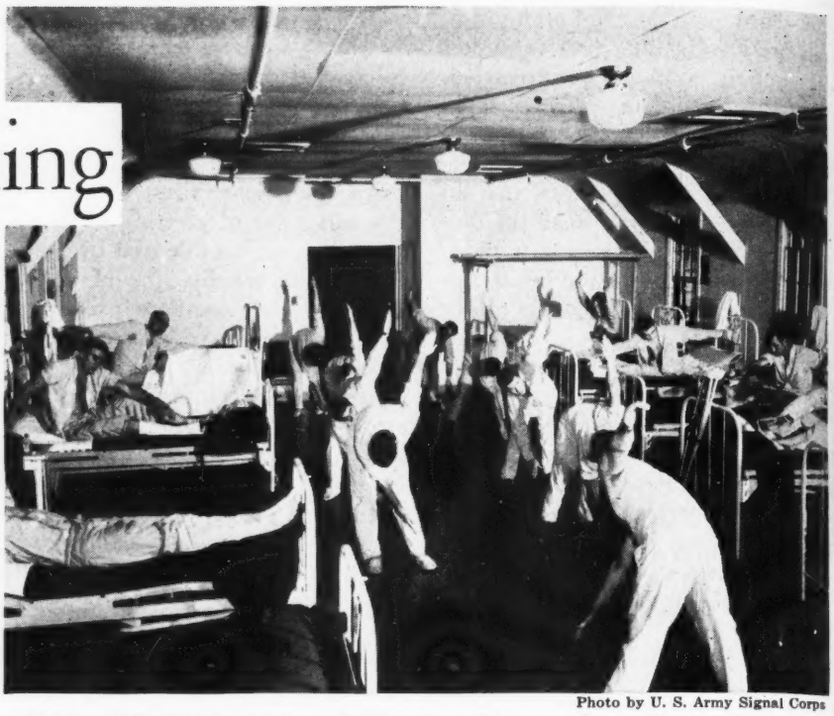


Photo by U. S. Army Signal Corps

No special equipment is needed by the soldiers at Camp Sutton Station Hospital as they perform calisthenics to strengthen weakened muscles.

IN THE past the term "convalescence" has been practically synonymous with rest, mental and physical. Unfortunately, rest too often means deterioration. In a great many instances it has contributed to the development of bone atrophy, muscular wasting, physiologic dysfunctions and, perhaps worst of all, to the development of emotional disturbances and anxieties related to illness.

However, the use of rest in the proper management of convalescence should not be underestimated and its value in certain medical conditions should not be completely overlooked and the patient embarked upon a dizzy round of activity which not only will not prove beneficial but will be actually detrimental to the patient's well-being. There is a happy medium in which mental and physical activity is scientifically prescribed in accordance with the patient's limitations that will prove of the greatest value in shortening convalescence, in lessening complications and in decreasing readmissions to the hospital.

Early in 1943 the War Department recognized the fact that a great many patients in Army hospitals were capable of indulging in constructive mental and physical activities, although they were not in condition to return to their military organization and still required medical supervision. Therefore, a directive was issued which placed all patients in U. S. Army hospitals in a convalescent reconditioning program consisting of mental and physical activities designed to occupy a large portion of a patient's day. These were to be suitably increased in intensity according to the progress of the medical condition.

It cannot be too strongly emphasized that this scientific management of convalescence is considered an integral part of professional care and is ordered and supervised by the patient's medical officer. This is not a boondoggling enterprise designed merely to occupy the patient's time but is a carefully planned scheme for diverting his mind from his illness, for rapidly increasing his physical strength and for occupying his mind with constructive mental activities of a type designed better to equip him for future Army assignments or for return to civilian life.

What has reconditioning, which was developed so largely under military auspices, to do with the civilian practice of medicine? The answer to that question will be found in studying the common objective of both military and civilian practices of medicine, which is the return of patients as rapidly as possible to their normal activities in a condition to engage in them successfully.

If convalescent reconditioning can shorten hospitalization, lessen complications and decrease readmissions, its everyday usefulness in civilian medical practice cannot be questioned. Through the Army's experiences, scientific data are accumulating to show that these goals can and are being achieved and there is no apparent reason why the Army's success cannot be duplicated.

The widespread inauguration of reconditioning programs in civilian hospitals will undoubtedly meet with a great deal of resistance from lay and professional sources. The old concept of the rest cure as propounded by Weir-Mitchell has become an ingrained part of the pattern of American medical practice.

However, certain bold leaders will quickly grasp the significance of this epoch-making change in medical practice and the practical results achieved by this group should, in a comparatively short time, bring the nonbelievers into the fold.

It is beyond the scope of this paper to give a precise pattern for a reconditioning program for all types of civilian hospitals. Each particular type, such as public or private, general or specialized, large or small, has its specific problem; however, certain general features of a well-balanced, professionally directed reconditioning program are applicable to all types of hospitals.

Occupational therapy is playing an increasingly important rôle in the rehabilitation program of the Army hospitals. Here, a therapist supervises the work of a patient at Stark General Hospital, Charleston, S. C.

Probably the most important first step in organizing a satisfactory reconditioning program is the establishment of reconditioning as one of the major professional services of the hospital under the direction of a capable medical man. It is necessary for the professional staff in a hospital to realize that this is another type of professional service which is an adjunct to the conventional services already provided in the hospital.

This service should be available to all patients at their physicians' discretion just as, for example, the x-ray and laboratory services are currently available. As the details of the program are explained, the quantity and quality of trained personnel necessary to supplement personnel already available in a hospital will be readily perceived.

For program purposes it is well to divide the patients into four categories. Class 4 is composed of those patients who are confined to bed because of physical limitations or because of necessity for certain types of treatments. Class 3 patients are those who have just been released from bed and in Class 2 are those who have progressed so far that hospital discharge is imminent.

Class 1 should be composed of patients who have reached a point in their convalescence where discharge from the hospital is warranted but who are still unable to return to their normal activities and who therefore should return to the hospital daily for a certain number of hours of participation in the Class 3 program.

Each patient, upon admission to the hospital, should be interviewed and his physician should be queried concerning his desires as to the patient's reconditioning activities. A daily schedule should be arranged and the patient should be given to understand that his participation is a part of his medical treatment and is as essential to his welfare as the medicine he receives or the operation he undergoes. This daily schedule should include calisthenics, remedial exercises when indicated, physical therapy and occupational therapy when indicated, orientation periods, educational periods, recreation and rest periods.

As the patient's strength improves, his classification changes and the extent of his activities varies and increases according to the dictates of his physician. A certain part of the beneficial therapeutic effect of reconditioning is achieved by the systematic and scheduled programming of daily activities.

Physical reconditioning in civilian hospitals must largely consist of general calisthenics. These should be of a type that will exercise all important body muscle groups and by so doing promote muscle strength, increase metabolism and promote circulation throughout the body. A set of exercises has been developed by the Army which safely permits beneficial exercising of patients who are confined to bed, as well as those who are ambulant.

In order to have properly conducted exercises, nurses should be trained in correct technics by qualified physical training instructors who should maintain general supervision of these activities. Certain groups of patients, particularly orthopedic and neurosurgical cases, require special remedial exercises to supplement the general calisthenics. These serve to exercise specific portions of the body affected by disease or injury.

Physical medicine is only beginning to be generally appreciated. The Baruch Committee of Physical Medicine and other such groups are rapidly educating both the public and the medical profession in the therapeutic possibilities of such modalities as massage, ultraviolet rays, infra-red rays, diathermy, whirlpool baths, faradic and galvanic stimulations and similar measures.

Special remedial exercises should be prescribed and supervised for patients confined to bed. A most important feature of the physical therapy department should be the remedial gymnasium equipped with medicine balls, skip ropes, weights, pulleys, shoulder wheels, horizontal ladders, rowing machines, Indian clubs and stall bars. These treatments should be individually prescribed and scheduled.

The advantages of occupational therapy have long been recognized in mental cases and to some extent in the treatment of orthopedic cases, but the benefits of constructive occupational activities as functional and diversional measures have not been generally appreciated in other fields of medicine and surgery.

Occupational therapy should be a prescribed activity for specific types of patients. Activities that are of interest to both men and women and that have definite therapeutic value to patients are woodworking, small metal work, ceramics, leather work, weaving, plastics and graphic arts.

Mental reconditioning includes analysis of personal problems, orientation, guidance and counseling and educational opportunities. Although the patient in the hospital is removed from his normal environment and activities, his interest in life and in the daily activities of the world in which he lives should not be ignored. Patients who are able should gather in groups to witness newsreel motion pictures, to hear discussions along group psychotherapeutic lines and to have the opportunity while in the medical atmosphere of the hospital to be indoctrinated in sound medical principles.

A great deal of the misunderstanding that has arisen in the past few years between the public and the medical profession might well be alleviated by discussion group methods of presenting social and medical problems. One of the greatest drawbacks to the patient's recovery from any illness is ignorance of disease, physiology and psychology which consequently causes anxiety and its manifold reactions.

A few minutes devoted to orienta-

tion of a patient or groups of patients about their disease on entry to the hospital will save countless hours of worry and will often prevent the development of psychosomatic disturbances.

In many hospitals social service is a well-developed feature of the service to the indigent but, frequently, life's problems multiply in proportion to one's income and often those who most need an opportunity to discuss everyday and extraordinary problems are denied this opportunity at the time they need it most—when they are in the hospital. Naturally, patients will often have problems that are beyond the scope of the social services appropriate to a hospital, but even in such instances great help can be afforded the patients by referring them to proper agencies outside of the hospital for further aid.

The term "education" is so often rigidly interpreted to mean academic pursuits that the very thought of educational opportunities being offered in a hospital must seem revolutionary. However, if the interpretation of education is broadened to mean the presentation of opportunities designed to challenge the interest and constructively to guide the mental activities of the patient while in the hospital, it will seem much more rational.

These opportunities should not mean the mere distribution of textbooks or the presence of a library, which is essential to a well-equipped hospital. They should include the use of audio-visual aids, which are just coming into their own and are revolutionizing the educational field. The presentation of music and news broadcasts by means of public address systems, of short motion picture subjects and of lectures by guest speakers or group discussions is highly recommended.

Recreation is definitely an integral part of a well-balanced reconditioning program, but too often the tendency is to permit the patient to take care of his own recreation. Unfortunately, this seldom proves satisfactory. Organized presentations of music, motion pictures and quiz programs should be available at regularly scheduled periods and these should be included on the individual patient's program.

Some would say that such a program as has been discussed is impractical because of the expense of facilities, equipment and personnel. The only possible answer to these objections is a demonstration of the actual saving of expense by the individual patient and by the community because of the shortening of a patient's hospitalization, the decrease in complications and the diminished number of hospital readmissions. Let us not forget the national economic burden of psychosomatic disorders alone!

Complete data are not yet available to support these contentions; however, it can be safely stated that the Army feels that the program has been worth while, because the budget for personnel, facilities and supplies has been constantly increased since the inception of the program.

Discussion From the Floor

ROGER DeBUSK, M.D.
Administrator
Evanston Hospital, Evanston, Ill.

WE HAVE long been cognizant of the fact that hospital care should not be regarded as "portal to portal" care. It is to this end that such services as those rendered by social service, follow-up clinics and visiting nurses have been directed. Unfortunately, it is a common happenstance that medical personnel too often regards the patient as a "case" or an isolated bit of pathology without considering him as a whole, physically, emotionally and mentally. Likewise, the disease process and its treatment do not receive the coordinated and complete consideration as ideally outlined by Major Gynn.

It is my opinion that the presentation of such a theme is worthy of effort directed to its attainment but, at the present time, practicality limits what hospitals can accomplish. The obstacles to be overcome are multiple. Financial obstacles exist both from the standpoint of the patient who is paying his own cost and from that of the hospital which is serving at less than cost. Facilities would have to be markedly increased to accommodate patients for the increased length of stay. Staffs of trained personnel would have to be available in increased numbers.

A program of public education as a forerunner is necessary since anything new, even though it is for the best interests of the patient, is often rejected unless the new technic is in pill form.

Although I am willing to grant that such an inclusive medical program is ideal, I feel that under our present voluntary system the attainment of such a goal will be a slow process and must be undertaken with care.

JACK MASUR, M.D.
Office of Vocational Rehabilitation
Washington, D. C.

MOST civilian physicians and hospitals have exhibited only a desultory interest in the process of convalescence. And as a matter of historical fact the interest of military surgeons in convalescence has been limited to the exigencies of war time. Major Gwynn has outlined the salutary effects of carefully graded and supervised exercise and recreational activities in a reconditioning program.

Recent medical reports on the abuse of bed rest for hospital patients have begun to dispel some of the traditional fear of premature activity. Experiences with postoperative, orthopedic and arthritic patients and those with certain respiratory illnesses have demonstrated clearly that early active convalescence is restorative and is more successful than the usual passive relaxation for an indeterminate period of time.

It has not been generally recognized that the boredom of convalescence is accompanied by considerable introspection and may produce psychological changes of varying degrees of severity. Sanatoriums and hospitals for long-term patients are more familiar with these problems than are the acute hospitals.

The impact of effective reconditioning programs in military hospitals on the thinking of medical officers will be transmitted to all our hospitals upon their return to civilian practice. The installation of a modified reconditioning program in certain parts of a civilian hospital would require only minor adjustments in some of our cherished routines. And it may well bring a belated recognition of the need for better understanding of the problems of convalescence.

Veterans Hospitals Can Meet the Coming Need

MALCOLM T. MacEACHERN, M.D.
Associate Director
American College of Surgeons

BEFORE the U. S. Veterans Administration lies a hospitalization and reconditioning program of greater magnitude than has ever confronted any single organization in history.

Observation of the conduct of the veterans' hospitals from their inception following World War I up to the present time leads me to declare that on the whole they should be credited with a notable accomplishment. Further, I predict that these hospitals can meet the coming needs provided they receive the confidence and support of Congress, of the medical profession and of the public.

89 Meet A.C.S. Standards

The American College of Surgeons has been surveying veterans' hospitals since 1924, when the United States Veterans Bureau, as it was known then, requested such action. Some 341 surveys have been made of 89 hospitals, the reports on which contain full information about their conduct and progress; all 89 of them have met the requirements of the minimum standard for approval by the college.

Recommendations offered for the improvement of conditions discovered in the course of surveys have invariably been acted upon promptly. The veterans' hospitals unquestionably compare favorably with civilian hospitals. At the present time some 20 veterans' hospitals are responding encouragingly to efforts of the college to organize programs of graduate training in surgery and the surgical specialties. Approval for such training is evidence of outstandingly superior service throughout an institution.

Through the work of the American College of Surgeons in its hospital standardization program, I am familiar with the development and administration of the veterans' hospitals and feel justified in suggesting certain adjustments or changes in their organization and administration which might be advantageous in meeting the oncoming load of World War II.

It is estimated that 15,000,000 people, embracing the veterans of all wars, will be entitled to medical care when this war is over. At the rate of five beds per thousand population, which is the average considered desirable for civilians, this would require 300,000 hospital beds for veterans.

Whether that many will be needed I am not prepared to state, but undoubtedly the need will be for more than 200,000 beds, at least 131,075 more than the 78,240 beds available in existing hospitals. No doubt some of the Army hospitals will be turned over for the care of veterans after the war. Nevertheless, an extensive building program will be necessary to provide the additional facilities.

Since World War I unprecedented advances have been made in all branches of medicine and in the institutional care of the sick and injured. Progress has been notable, particularly during the last decade. National organizations have set high standards of medical practice; there has been intensive and extensive specialization in all fields of medicine and surgery; new methods and discoveries have resulted in a greatly increased number of intricate procedures in our hospitals. In the postwar period many more changes and new developments will occur.

The recent creation of the Commission on Hospital Care, which is financed by private foundations and is assisted in its work by the U. S. Public Health Service, is one of the significant evidences of a generally recognized need to evaluate all of our hospitalization resources and to determine how they should be supplemented and improved to meet the postwar needs. In line with this general trend, therefore, it seems eminently desirable that the medical and hospital services of the Veterans Administration be studied and developed to ensure that their future functioning will reach maximum effectiveness.

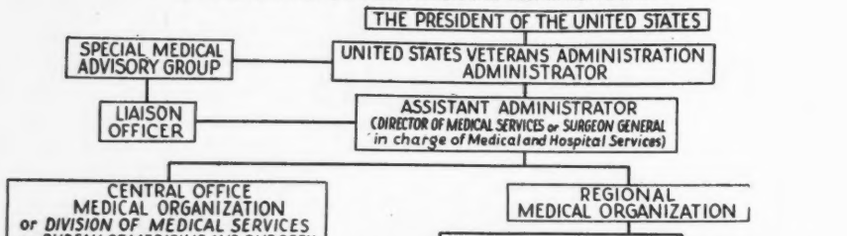
Advisory Group Appointed

A step in this direction was taken in 1944 through appointment of the Special Medical Advisory Group to the administrator of the U. S. Veterans Administration, the chairman of which is Dr. George Morris Piersol. The members, consisting of counselors in 15 specialties, advise with the administrator and formulate policies to meet the new needs and to assist the Veterans Administration to keep abreast of the advances of medical science.

To accomplish this end the medical division of the Veterans Administration must have sufficient prominence and authority. Red tape and politics must have no place. New practices must be quickly adopted in the individual hospitals in order that the veteran may be assured the best that medicine can offer.

After years of close association with the Veterans Administration hospitals I would offer the following suggestions as a basis, in principal at least, for adaptations which seem desirable at this time:

SUGGESTED BASIC ORGANIZATION OF THE MEDICAL AND HOSPITAL SERVICES OF THE UNITED STATES VETERANS ADMINISTRATION



ORGANIZATION OF MEDICAL SERVICES

The status of the medical division should be changed by creating the post of director of medical services, U. S. Veterans Administration, to replace the former position of medical director and by making this official an assistant director of the administration. Legislation now before Congress in Bill H.R. 3310 provides for a surgeon general in the Veterans Administration as in the other federal medical services.

The director of medical services (or surgeon general) should head an organization comparable with that of the Bureau of Medicine and Surgery of the Navy, having assistant directors in charge of the various professional services, that is, medicine, surgery, neurosurgery, dentistry, radiology, rehabilitation, pathology, physical medicine, research and postgraduate instruction. A liaison officer of the special medical advisory group should be appointed as a member of this bureau or department.

Inspection. The heads of the various medical and hospital services in the central office should make frequent visits to the hospitals throughout the country. Veterans' hospitals have always been under the inspection of the central office but, owing to limited staffs and a rapidly increasing load of work, the visits have not been as frequent as desirable. Each hospital should be visited every six months and the inspection should involve particularly the medical or professional care of the patients.

The inspections should be regular, thorough and complete and their primary purpose should be to investigate the quality of care rendered the patients. The administrator and the director of medical services of the Veterans Administration should personally visit as many hospitals as possible in the course of a year.

Regional Consultants. A plan that would provide regional consultants in medicine, surgery, tuberculosis, neuropsychiatry, physical medicine and rehabilitation, who are specialists of recognized standing in their respective fields, would be a great advantage. Such a plan would follow the pattern of the Army in each service command where there are consultants in the major fields of medicine and surgery.

These consultants would visit each hospital in the region or assigned area at regular intervals, possibly three or four times a year, and remain long enough at the station to see all the cases in their particular services. This plan seems to be working well in the Army and it could be applied equally well to the medical service of the Veterans Administration provided there is a careful selection of the regional consultants.

Heads of Clinical Services. It is highly important to establish the best medical services possible within each hospital. This presupposes the maintaining of a medical staff of well-qualified physicians and surgeons to cover all the fields of medicine and surgery. The heads of the various clinical services should be recognized specialists in their respective fields.

Following the example of many voluntary civilian hospitals today, it would be advisable and advantageous for the authorities in charge of veterans' hospitals to consider, so far as is practicable and possible, appointing as heads of the various services in these hospitals fellows of the American College of Physicians or of the American College of Surgeons and/or diplomates of the various specialty boards, now numbering 15, or medical officers of equal standing.

In every community there are certain highly qualified physicians and surgeons, proficient in their respective fields, who are not fellows of either of the colleges or diplomates of the boards. Through examination or a credentials committee the eligibility of such men could be determined before an appointment is made. It is understood that all the medical officers in the Veterans Administration cannot acquire the standing of recognized specialists, but the younger members of the medical staff should aspire thereto and be encouraged to obtain recognition in the various fields as soon as they are prepared.

Possibly, after graduate training has been set up in general surgery and the surgical specialties and in general medicine and the medical specialties, opportunities for training will be available for the younger medical officers in the veterans' hospitals so that they can advance into fields of recognized specialties.

Hospital Consultants. Recognized, competent consultants in selected major services should be appointed to each veterans' hospital. These consultants should preferably be from the local medical school or medical center. Each consultant should be compensated adequately for his time and professional services and have a regular day of visit to the hospital, during which he should make rounds and see all the patients on the service rather than merely the case or cases for which he might be called. He should make what is known as "grand rounds" and the medical officers on the service should accompany him.

Discussion and bedside instruction would be most valuable to the members of the medical staff and particularly to residents and interns. The consultant should also attend and participate, if possible, in any clinical conferences held during the day of his visit. In establishing this service it should be placed on a definite basis as to compensation, day and hour of visits and such other regulations and policies as would assure obtaining the best service from the consultants.

Medical Secretaries and Dictating Equipment. The medical officers of the veterans' hospitals have too much paper work under the present system and the addition of medical secretaries and dictating machines would be most advantageous. Trained medical secretaries are available. Dictating machines facilitate writing medical records. A large number of these machines will be available after the war. Plans should be set up within each hospital to relieve the medical officers of a large amount of paper work, allowing them more time for clinical duties.

MEDICAL CORPS

It would be advantageous to establish a medical corps in connection with the Veterans Administration. This has been recommended by the medical council of the Veterans Administration and more recently by the special medical advisory group. Such an organization is also recommended in Bill H.R. 3310.

This would be of distinct advantage in maintaining a high-grade medical service and would be preferable to the Civil Service type of organization that now exists. If such a medical corps is not established, a medical board of recognized competence could set up standards for the various medical services. Such a board would advise on all appointments of medical officers to the veterans' hospitals and other medical services.

EDUCATIONAL ACTIVITIES

Serious consideration should be given to the training of interns and residents and to graduate training in medicine and surgery. A number of veterans' hospitals could readily set up educational activities of this nature. A recent survey by the American College of Surgeons of 20 veterans' hospitals showed excellent potentialities for establishing three or four years of graduate training in general surgery and/or the surgical specialties, contingent upon reorganization of the medical services. Through this means the hospital could be better assured of well-trained, competent medical officers.

SEGREGATION OF PATIENTS

A more complete segregation of the three types of patients in veterans' hospitals, that is, the acute, convalescent and chronic, should be considered. Separate and appropriate accommodations should be provided for convalescent patients and those whose illness has become chronic.

This will have an important bearing on the administration of the hospitals and more particularly on the clinical condition of the patients. It is urged that in the new program of hospital construction, now being undertaken by the Veterans Administration, due attention be given to providing adequate accommodations for segregating these types of patients.

ADMINISTRATION

The chief medical officer of each veterans' hospital should, in effect, be comparable in authority to the commanding officer or head of the hospital in the Army and Navy and should be responsible to the assistant director in charge of medical and hospital services. This officer should have administrative ability and experience as well as clinical knowledge and should be selected with due care as to his professional status in his special type of work: general medicine or surgery, tuberculosis or neuropsychiatry. He should be a well-recognized specialist in the type of work conducted in his hospital.

There should be a sufficient number of clinical and administrative assistants according to the size of the institution. The chief medical officer's responsibilities would involve management of the entire institution, particularly the professional care of the patients. He, as well as the other medical officers and the consultants, should be adequately compensated for his services.

In order to relieve the chief medical officer of many administrative duties it would be advantageous if he had an adequate number of administrative assistants to supervise administrative details, working through well-organized departments with competent heads for conducting the various activities incident to the care of the patient.

Such administrative assistants could be trained competent laymen or medical men who prefer administrative to clinical work. Such persons must be properly trained for their duties. It has been estimated that 18,000 men are in the Medical Administrative Corps of the Army, and this group might well be a source of supply, if trained.

Looking forward to postwar needs, Northwestern University has set up a program in hospital administration in the school of commerce, in cooperation with the medical school and the university college on the Chicago campus. This school has been in operation since September 1943 and is prepared and willing to train prospective administrative assistants for Veterans Administration hospitals.

Through a specially conducted institute or longer course these men could be well grounded in the basic principles of hospital organization and management and their practical application to Veterans Administration hospitals.

The very nature of these recommendations, made after the closest study of conditions in the veterans' hospitals, will disclose that a minimum of disturbance to the existing institutions would be involved in activating them. They are for the most part aimed at strengthening the present organization rather than at changing it. The foundation is sound.

With certain structural changes and the erection of a more ambitious edifice in keeping with the gigantic needs of the times, the medical division of the Veterans Administration will, I am sure, be prepared to provide facilities and services for hospitalization of ill and disabled veterans that will satisfy all of us who are concerned that the most scientific and sympathetic treatment possible be given those who have suffered in the service of their country.

Having worked closely with General Hines, I want to pay highest tribute to his sincerity, perseverance and accomplishments. General Omar Bradley faces a great challenge but comes with the favor of all concerned and a splendid record.

A Constructive Contribution to the Comfort of the Aged

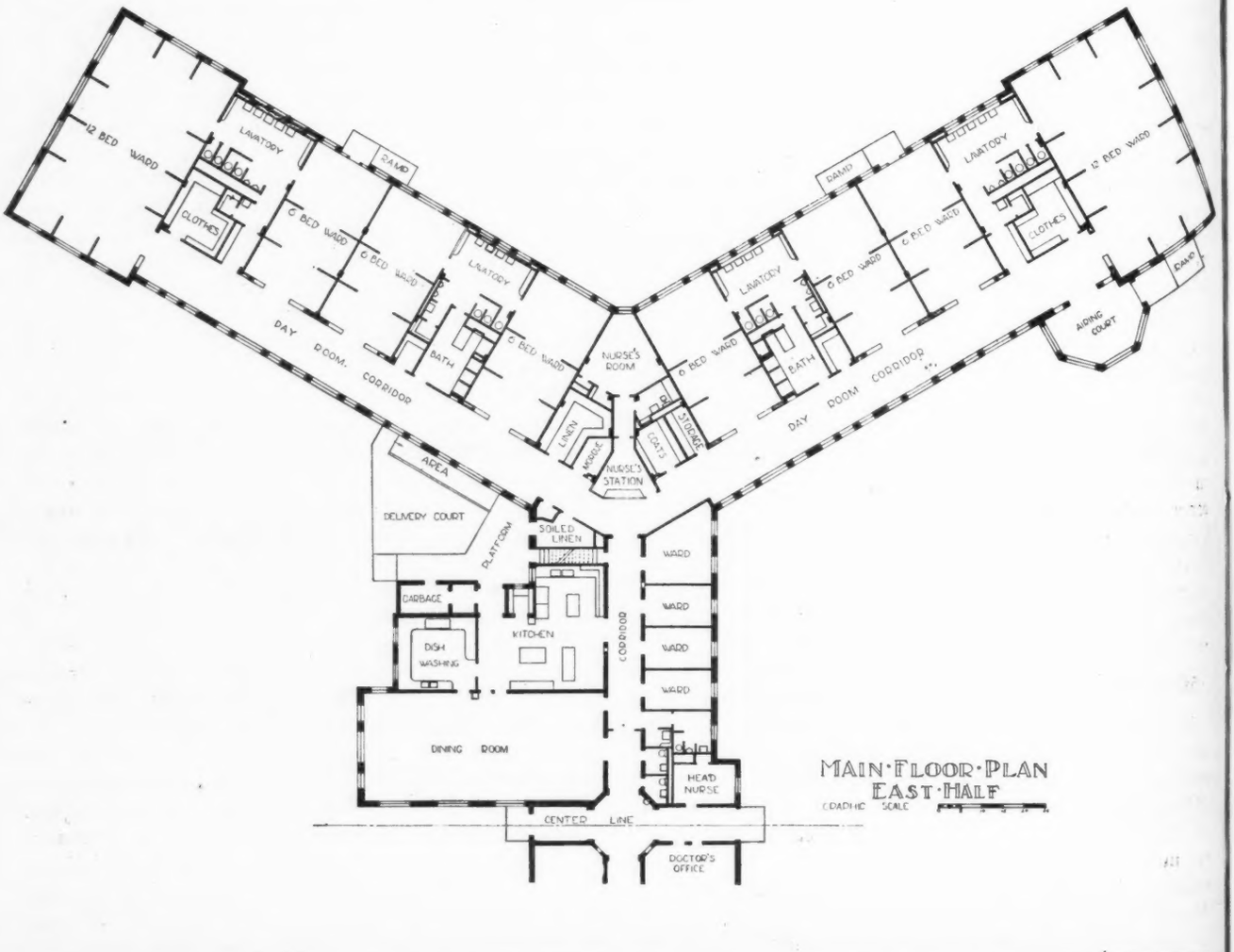
GEORGE GOVE
Heath, Gove and Bell
Mock and Morrison
Associate Architects
Tacoma, Wash.

EVIDENCE of the great and growing interest in geriatrics is shown in the recent opening of a 300 bed ward building at Western State Hospital, Fort Steilacoom, Wash., situated 10 miles from Tacoma near the shores of Puget Sound. This building is the first unit of a project for a semidetached adjunct to the main group of the hospital, which now accommodates 3000 patients. As the plot plan shows, it is intended to add a women's building of similar design, with a small administration pavilion between them, connected by covered walks.

The main feature of the plan is the wide-openness of the wards; one side of each ward has only low bookcases to separate it from a glazed corridor or day room, 12 feet wide, extending the full length of the sunny side of each wing. The opposite side of each typical ward is practically all windows.

The wings are set at 60 degree angles with North so as to ensure the maximum of light and air. The large wards on the ends of the wings have windows on three sides.

Each pair of wards has a lavatory section located between them. Pairs of beds are separated by permanent low screens.



Ample space for linen, clothing, outdoor wraps, blankets, rubbers and floor polishers is allotted.

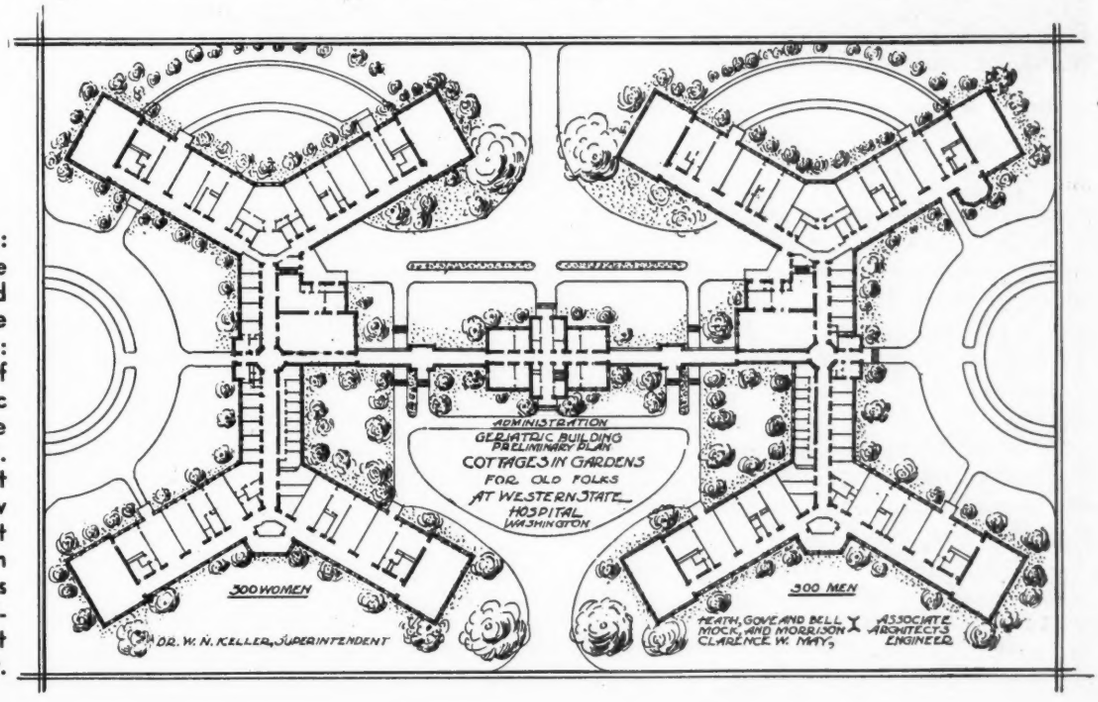
The nurses' stations have glass screens projecting into the corridor so that the view is unobstructed for the full length. A bedroom, bath and closet are close to each nurses' station and at the center of the building a matron's room, information counter and doctors' office, with treatment room adjoining, are arranged.

It is estimated that one fourth of the patients will be bedridden, and 25 of the more troublesome are accommodated in single or double rooms opening onto a secondary corridor for the worst cases. This setup leaves about 200 patients to be fed in the dining room.

The dining room is a beautiful, light room adjoining a serving room, with dishwashing and storage facilities. The food is brought in heated carts by truck from the main kitchen of the institution about one fourth of a mile distant. The serving room is completely furnished with food carts, large refrigerator and range, and the dishwashing room is insulated and has double glass.

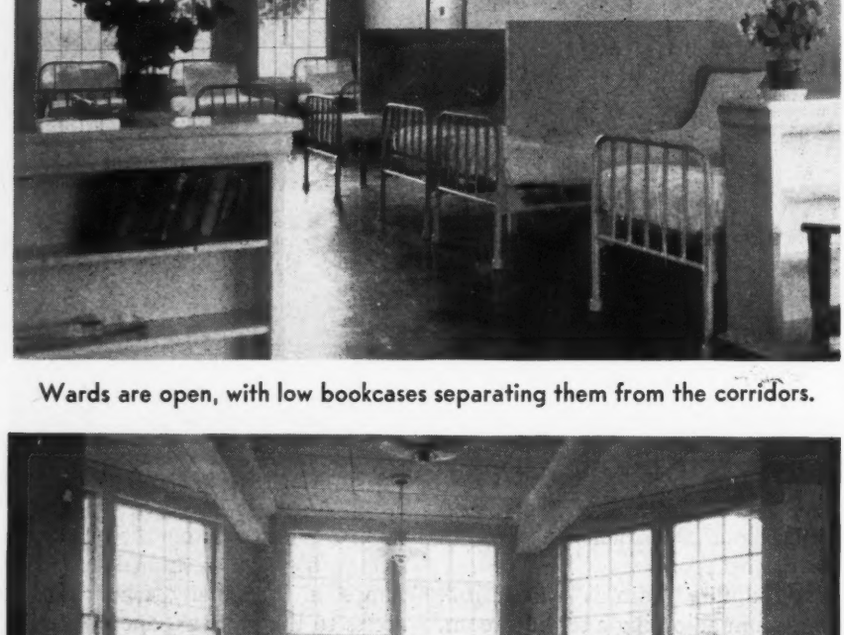
The site is gravelly and has been raised about 2 feet above the grade; the concrete floor slab is laid directly on it and has ½ inch of mastic waterproofing on top in which the asphalt tile floor is embedded. Easy ramps at the many exits provide access to the gardens, one of the advantages of a one story building.

The construction, owing to W.P.B. restrictions, is extremely simple. All exterior walls are of brick laid in cement mortar, with 3 inch clay tile furring inside. All partitions are of clay tile resting on concrete plinths. The ceiling and roof consist of 3 by 6 inch grooved and splined, beveledged material resting on heavy timber trusses without any rafters, to



Opposite page: Main floor of the 300-bed ward building for male patients. Above: General view of the Geriatric Building from the opposite hill. Right: The plot plan shows how the entire project will appear when the women's building and administrative unit have been built.

Wards are open, with low bookcases separating them from the corridors.



Ample window areas enhance the attractiveness of the sun rooms.

minimize the fire hazard. The roof covering is rigid asbestos shingles.

The building is plastered throughout the interior except the ceilings which are of 1 inch acoustical board, laid in patterns and left unpainted. All walls are painted with three coats of washable paint with dull finish stippled.

All wood trim and doors are of fir, painted and enameled. Particular attention has been given to the color schemes throughout. The floors of all rooms, wards and corridors are 3/16 inch marbelized asphalt tile. All toilet rooms, baths and serving rooms have ceramic nonslip tile floors, with tile base, wainscots and casings.

Owing to the impossibility of obtaining steel sash in small lights, with horizontal ventilating panels, such as the architects have used in other buildings of this hospital, it was necessary to use heavy wooden sash divided by strong muntins, double hung and with limit blocks for opening. No trouble has yet been found with these wood sash as the age and character of the occupants reduce the danger of escape.

Laundry is sent to the central laundry. Heat, light and power come underground from the central power house. Heat is supplied by fans drawing air over banks of cast-iron blast coils located in the attic and distributing it to all spaces through ceiling diffusing outlets, figured on supplying approximately eight changes an hour. All enclosed rooms, baths, toilets and serving and dish-washing rooms have exhaust ducts with fans in the attic, at approximately 20 changes an hour.

The lighting system is quite complete, incandescent semi-indirect ceiling fixtures with subdued night illumination being used. Corridors are controlled from main panels. Wards are locally controlled. All spaces except wards have 25 foot-candles or more.

Plumbing is of the best procurable at this time, ample in quantity and convenient in distribution. Hot water comes from the power house; accessible pipe shafts are provided for all major groups of fixtures, with concealed flush valves for toilets. Dental lavatories, an unusual feature, are provided. Showers are generally used, with control by attendant, and free standing tiled-in bathtubs, raised to convenient height, are used for feeble patients.

No attempt whatever has been made at architectural embellishment, either outside or in; rather, we relied on landscaping, variegated brick surfaces and subtle color for decoration. However, ample service, convenience and as much privacy and comfort as the extremely low cost per bed permitted have been developed.

Landscaping is an important adjunct to hospital design, and the entourage of this group of wards will exhibit such lovely gardening as only Puget Sound's mild climate can produce.

The total cost of the structure was approximately $300,000, which includes $39,000 for heating, $26,000 for plumbing, $15,000 for electrical work and $25,000 for furnishings and food equipment. This amounts to $1000 a bed at normal capacity.

Through the cooperation of the superintendent, Dr. W. N. Keller, who has been the inspiration of all the new building at Western State Hospital, and the engineers of the project, and with the sympathetic encouragement of the state officials in this pioneering enterprise, we feel that it is a distinct contribution to geriatric science. When the female wing and administration units are completed, the whole setup will form a unique demonstration of modern provision for the aged mentally ill.

Psychiatric Hospitals Have Six Chances to Serve

SAMUEL W. HAMILTON, M.D.
Mental Hospital Adviser, U. S. Public Health Service, Washington, D. C.

WHY are we in such position that we have to keep insisting in order to ensure patients in our mental disease hospitals not only the best treatment but even decent, kindly care? When standards have once been set, why can we not expect that local authorities will live up to them? Why can we not take one thing for granted, *i.e.* that the first part of our job has been done after thirty-odd years, and put all our energies and our resources, all too meager as they are, into other urgent problems of mental hygiene?

Perhaps we are more humble than we should be. General hospitals do not function perfectly and the American College of Surgeons and the American Medical Association can tell tales of evils that recur even after they once seem to be corrected.

Must Combat Unkindness

Sometimes one thinks that our problem of assuring kindly care will never be fully solved, for unkindness is fundamental in human nature and must always be watched for and combated where persons of contrary temperament (as are many of the mentally ill) must be taken care of by other human beings who are subject, in the nature of the case, to faulty rearing, to lack of understanding, to prejudice and to emotional outbursts.

So many things need to be done for our patients, and it is to be expected that some hospitals will have done better than others. Accordingly, the deficit in each hospital makes an opportunity for somebody to improve matters. A few such opportunities may claim our immediate attention.

1. The first opportunity that I would emphasize is that of assuring patients that those who take care of them will be persons of reasonable intelligence, of high devotion to their duty and of as much training as can usefully be provided. The number of mental disease patients increases steadily and will continue to increase, no doubt, so long as the expectancy of human life in this country increases, for where the number of old folk is great, the number of mentally ill old folk is greater still.

To care for mentally sick people, there must be employes with a variety of talent, but the two largest groups are the nurses and attendants. We should seek to assure our hospitals of a material number of psychiatrically experienced nurses. It would be wonderful if we could have one such nurse to each 25 patients. We can do a very good job with one to 50, and if we are given one to 75 we will get along; but not everywhere are we given even that ratio.

Then, there are the attendants. There ought to be enough attendants in addition to the nurses so that the total ratio will be about one to 5.6 or 5.7 patients. If we could have a better ratio we could do better work, but I am not asking for something extraordinary and unprecedented. We used to do well with one to eight with the two-shift system, but the two-shift system is out of style and it is quite right for state authorities to prescribe shorter working days, provided they will give us the people to do the work.

These attendants will not be as well schooled as the nurses; many of them will be essentially motor-minded rather than eye-minded and, for that reason, not capable of so much academic education. That is of no consequence. We need some well-educated people with our patients, but we do not need all our workers to be high school graduates. What we do need is a salary schedule that will enable us to employ persons of good background and the right temperament.

We then need a program of training. This training should not be a replica of what is given to student nurses—the sort of thing that at least one state has attempted to set up. It should be a program based on the intellectual capacity of the people for whom it is designed and it should include a great deal more of demonstration and of ward supervision than of lectures. As time goes on, we shall do much with moving pictures but thus far not many films are useful.

2. The second opportunity is to make sure that the best treatment is administered. Here we get into the field of medical qualifications. I do not propose that any society for mental hygiene should attempt to prescribe the details of treatment for patients but it should be in a position to demand that the right kind of physicians in adequate numbers shall constitute the staff of every psychiatric hospital.

Salaries Must Be Adequate

Salaries have a great deal to do with this. It is all very fine to say that the opportunity of service to an unfortunate group is so great that a physician should be willing to forego a comfortable income in order to serve humanity. Since physicians seem to be serving humanity whether their incomes are small or large, this argument falls rather flat. A state that thinks so little of its physicians that it does not give them opportunity to live comfortably has no right to expect that it will obtain the services of really able men for any length of time. Able men will come

From a paper presented to the National Committee for Mental Hygiene, November 1944.

and will go; less able ones may stay.

Of course, terms of appointment and security of tenure enter in, and those states in which a physician can expect to lose his job the next time the governor changes are not the states that can expect the best medical service. Sometimes neighboring states vary greatly in this regard. I think there is a tendency among hospitals toward stability, but it may be simply the decrease in the supply of physicians because of the war that has made things seem more stable in some states where the primary function of the state hospital is thought by many important people to be to bolster the dominant political group by furnishing jobs to its henchmen.

Interviews Are Most Important

As regards the best treatment, we need say little about equipment, for that will be obtained if the right persons are on the staff to use it. The most important work that is done for our patients is in the stated interviews with their physicians, and where stated interviews are few and brief the highest standard of treatment does not exist.

Psychotherapy has not always been taught as it should be, even in hospitals that maintain generally high standards. Our hospitals should not depend on everything else except working directly with the state of mind of their patients.

3. Another opportunity is to make the mental disease hospital a center of all mental hygiene work. It need not be the only center. I suppose the office of the state society for mental hygiene is highly important but, certainly, the state hospital should be a place where we can expect any type of activity for mental health to receive serious consideration, sound advice and, probably, at least some initial assistance.

The first implication is that outpatient work will be carried on by certain members of the staff of the hospital. Generally, a public mental disease hospital that has no outpatient work is not doing the best in-patient work either. The interrelations are important on both sides.

If information is sought by local groups, somebody at the state hospital ought to be able to give it. Indeed, there should be several people at every state hospital who could go into a luncheon club or an evening session of a local society and talk definitely and interestingly about any subject in our field.

4. The public mental disease hospital should be a great teaching post. Young physicians come to the hospital to learn the principles of psychiatric examination, diagnosis and treatment; older physicians, when the community is properly organized, come to it from time to time to be given clinical demonstrations and to hear discussions on important problems of treatment. Special therapists of several sorts may be given a valuable part of their training in a mental disease hospital.

Schools of occupational therapy usually place some or all of their pupils in selected state hospitals for a period of field work and, in a few places, students of physical therapy have a similar experience. Thus far, students of physical education have not come to psychiatric hospitals on any systematic basis, but some of them have been put to work in vacation time in these institutions and not only bring fresh knowledge of their craft but also learn much themselves. Students of psychology are accepted in several institutions for some of the work upon which they qualify for advanced degrees.

It is to be hoped that more students of law will obtain some experience in mental disease hospitals and thereby develop a deeper feeling for the human beings for whom they make and administer the laws. Students of theology have worked to excellent advantage in a few of our hospitals where pains were taken to appoint to the staff a clergyman who already understood the nature of the work and the teaching to be undertaken.

A vast amount of teaching of student nurses, and some of graduate nurses, is done in the best psychiatric hospitals. At this very time there is a great demand for more mental disease hospitals to set up affiliate courses of instruction for the problems of general hospitals. Every now and then another hospital undertakes such work but the need is by no means met. We do not complain, for the difficulty lies less in the will than in the lack of competent instructors.

There should be more and better training for male nurses when the war is over. Perhaps the experience of some medical corpsmen will lead to an adequate supply of this type of help for a year or two, but we know that most of the corpsmen will do other work after the war. We have to enlist the right kind of boys when they are still in the formative stage and give them definite training ourselves.

5. Mental disease hospitals have a tremendous opportunity for usefulness in the community through active participation in the lives of former patients. Some hospitals approach this subject with all the resources they have. A few utterly lack imagination as to what could be done. The first opportunity here is to develop an active and highly competent social service. Even this is hardly enough. Although the worker can bring reports to the physician at the hospital, his judgment on cases should not depend entirely upon long-distance reporting.

Develop Out-Patient Posts

The hospital should develop suitable out-patient posts, giving the physician an opportunity to go to them at stated intervals and to see such former patients as need his help. Inevitably, from such a start additional out-patient work develops. The social agency and the children's court are equally prompt in seizing this opportunity for help.

Wherever out-patient clinics exist, the calls made on them come to be so many as to be embarrassing. Nevertheless, if people do not have means to consult psychiatrists in private practice, it is somebody's duty to see that the community provides the clinical help that is needed.

6. We must think of our institutions for defectives and epileptics not only as schools but also as hospitals. Their educational function is highly important, but both types of institutions house many patients who need much more than schooling, many, indeed, who require a great deal of fundamental medical care as well as psychiatry. Here, then, we have an opportunity to develop in such institutions a wholesome influence on special education throughout the public and parochial school system. In some places this influence is felt.

No doubt other opportunities exist for the improvement of our public mental disease hospitals. These six, however, might well be put on our agenda for prompt and vigorous action.

Health Service Must Be Expanded

For Mothers and Children

MILDRED F. WALKER
Consultant in Hospital Administration
Children's Bureau
U. S. Department of Labor
Washington, D. C.

UNDER the Social Security Act the Children's Bureau, U. S. Department of Labor, has administered grants to the states for maternal and child health and crippled children's services for nine years. Throughout this time groups of professional and lay persons interested in the health and welfare of the mothers and children of the nation have been serving on committees working with the bureau to develop ways and means to effect improvement of these services.

The Children's Bureau has thus had the benefit of the advice of outstanding leaders of the medical profession in the fields of obstetrics, pediatrics, orthopedic surgery and public health, and of hospital administrators, nurses, medical social workers and others who are authorities in the wide variety of services provided in hospitals, clinics and health centers.

Children Have Been Neglected

These committees have been concerned with the shocking situations the war has pointed up. The rejection of more than one in four of our 18 year old boys as physically or mentally unfit for military service highlighted what had long been known but to some extent disregarded, namely, that a large proportion of the nation's children are not reaching maturity as physically and mentally fit as is consistent with the knowledge and potential resources available in this country.

The committees have taken cognizance of the inadequacy of facilities for proper hospitalization of maternity cases; the undesirable conditions under which infants and children are cared for in many hospitals; the total lack of beds in many areas, and the great number of handicapped children who are receiving inadequate or no care.

National Affairs

10 Senators Sponsor Bill For Free Maternity Care

$100,000,000-a-Year Program Planned; States Would Have to Match U.S. Funds

By Paul B. McGee.
Chicago Sun Washington Bureau.

WASHINGTON, July 26.—Far-reaching legislation to provide a $100,000,000-a-year program for the medical care of American mothers and children was introduced today by a tri-partisan group of senators led by Senator Pepper (Dem., Fla.).

The proposed 10-year program of federal aid to the states would provide complete maternity care, including prenatal and postnatal service, to all mothers who "elect to participate in the benefits of the program."

The states would be required to match, dollar-for-dollar, the federal funds appropriated.

In addition, the bill would provide preventive, curative a[nd] ive services for child

U.S. District Court for the Southern District of New York, the department accused the defendants of restricting competition leasing two [illegible] which stir

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Although there is evidence that during the nine years the Social Security Act has been in operation great progress has been made, with marked reduction in infant and maternal mortality, it is well known that in many parts of the country mortality and morbidity rates are far greater than average. The Children's Bureau committees have stressed the fact that many children do not receive preventive and curative care compatible in amount or in quality with present day standards of good pediatric service and that many mothers do not receive the kind of obstetric care that is recognized as best.

They have pointed to the causes—services and facilities are not distributed widely but are concentrated in larger urban centers; many families are unable to pay for service even when it is available in the community; neither the availability nor the provision of medical care nor the education of parents as to how to use facilities has kept pace with scientific knowledge.

Awareness of such conditions has called for comprehensive planning for the future. A significant statement adopted by the American Academy of Pediatrics at its meeting in St. Louis last November was reiterated by the advisory committees as the keynote of the goal to be sought—"to make available to all mothers and children in the United States all essential preventive, diagnostic and curative medical services of high quality which, used in cooperation with the other services for children, will make this country an ideal place for children to grow into responsible citizens."

It's an Immediate Need

This is not thought of as some far distant goal but as something to be accomplished within the next ten years. It was recognized that "efforts should be made to obtain from the Congress and from state legislatures adequate financial support" so that funds will be available for progressive expansion of programs until we have statewide coverage of services of high quality to meet the needs of mothers and children as individuals. Recommendations urging the Children's Bureau to take definite steps toward helping the states to attain this goal may be summarized as follows:

1. Expansion of community health services to include all mothers and all children is regarded as essential.

Such health services should make available periodic health examinations and should provide for medical and hospital care, dental health service and care and mental health services throughout every state. This entails special attention to school health and hospital clinic services.

2. The standards of school health services need improvement. The services of preventive, diagnostic and treatment agencies must be coordinated with programs of health instruction in departments of health, education and welfare. Normal school and in-service education of teachers must be undertaken.

3. Adequate hospital and clinic services are needed. They must provide for continuity of care. More maternity and pediatric beds must be sought. Better facilities for the care of premature and newly born infants and beds for children with communicable diseases and those whose illness requires prolonged sanatorial or convalescent care are sorely needed.

Maternity and Child Health

The advisory committee on maternal and child health has stated that it is "the consensus of the committee that the Children's Bureau, in planning for better maternity care in the postwar period, should envision a long-term program directed at lowering maternal and child mortality and morbidity to an irreducible minimum. It was the unanimous feeling of the committee that this end can best be achieved by the delivery of all women in good hospitals and under the care of competent physicians."

The attainment of such an end must be the concern of hospital administrators since they hold the ultimate responsibility for "good hospitals" where care is rendered by "competent physicians." These are ends for which great efforts will have to be exerted.

Obstetric and pediatric, mental health and dental consultants employed on the staff of each state health department are thought to be necessary. Their services are needed to supervise clinics in their special fields and to coordinate service in clinics with care in hospitals so as to provide for continuity of service. It is expected that they would also serve in a consultative capacity to local physicians on the care and management of obstetrical and pediatric patients.

A school health unit and consulting psychiatric staff developed within the Children's Bureau is believed necessary to provide the assistance to the states that is needed in these special fields.

Nationwide education in what constitutes adequate care during pregnancy, infancy and early and later childhood must be undertaken. Programs of adult education in health subjects with emphasis on education for parenthood need to be developed by state and local health agencies.

Hospitals and Health Centers

The marked increase in the number of women seeking hospital care at delivery is recognized—an increase from 37 per cent in 1935 to 68 per cent in 1942 (and even more in 1944). With the trend toward the hospitalization of all maternity cases, early attention must be given to the building of maternity units. The problem of distribution of beds must be given adequate study. More obstetric beds are urgently needed in some localities and not in others, and there must be particular planning in those places where the lack of provision for Negro women and children is especially great.

In viewing the need of hospital facilities the advisory committees to the Children's Bureau have specifically recommended, "in the development of plans for hospital construction, special consideration should be given to the need of making adequate provision for maternity beds and for pediatric beds, including those for new-born infants, for children with communicable diseases and for children requiring prolonged sanatorial or convalescent care."

Early attention to the building of maternity units as sections of general hospitals was stressed by the committee on maternity care. The committee also recognized the fact that in certain areas it may be desirable to build separate maternity hospitals but that such units should always be connected with general hospital services and with health centers.

More adequate children's services in medical school clinics are viewed as an important need and the establishment of children's hospitals in association with general hospitals or medical schools is to be encouraged.

More properly equipped nurseries for new-born infants are seriously needed.

An expanded program of care for premature infants must be inaugurated, in the opinion of the advisory committee, "to the end that all general, children's and maternity hospitals shall be equipped with modern nurseries under the supervision of qualified pediatricians and pediatric nurses." This point of view should be of particular importance to workers in the hospital field.

The problem of premature birth is believed to be of such importance that state health agencies should designate it as a reportable condition of an emergency character and emergency transportation facilities should be provided when necessary.

Integration of preventive and curative facilities in both rural and urban communities is stressed. This will undoubtedly need to be considered in the thinking and planning that states are now undertaking in hospital surveys. It is believed to be highly desirable that general hospitals should be health centers designed to supply all types of medical services to a given area, urban and rural alike.

Health centers need to be developed at the periphery of a central hospital and administrative center. It is believed that x-ray and laboratory facilities for principal diagnostic procedures should be made available to the local physicians as needed in their practice. These centers should be used for preventive services, prenatal and well-baby conferences and clinics, preschool and school services and should be integrated with a central hospital and with the activities of a school health program. They would serve as a place for professional society meetings and furnish offices for county and district health departments and possibly offices for physicians. Such centers should eventually be worked out for rural and urban populations.

Crippled Children

Expansion of services for crippled children is urged by the advisory committee on crippled children "to provide full and complete care for all children who suffer from any kind of physically handicapping condition or any condition that may be potentially handicapping. Efforts should be made to obtain from the

Congress and from state legislatures adequate financial support to make full and complete care under such expanded programs possible in every state." The committee singled out for particular planning on the part of the Children's Bureau the following conditions:

Rheumatic Fever. This being the leading cause of death from disease among children of school age, it is advised that a program should be developed in each state that will include diagnostic and treatment services and after care on a statewide basis.

Cerebral Palsy. Emphasis must be placed on prevention through competent obstetric care and on the establishment of special centers for the training of children suffering from this condition.

Other Physical Handicaps. Diagnostic and treatment services should be extended to include children of all ages with handicapping conditions, such as visual and hearing defects, asthma and diabetes.

Elimination of Court Action. It was the conviction of the committee that the Children's Bureau and the state agencies should work for the elimination of court action in determining eligibility of children for care under programs involving federal grants-in-aid to the states for crippled children in the 13 states that still have this requirement. The committee also states that inasmuch as these programs involve medical care they should be administered by departments of health in each state.

Federal Responsibility

Provisions that would assure a high quality of care for mothers, infants and crippled children were given detailed consideration, and it is the expressed opinion of these advisory committees that the Children's Bureau should: (a) develop national standards and establish minimum requirements; (b) provide grants-in-aid to the states to make equalization of opportunity for a high quality of care possible, and (c) aid in the training of personnel.

The last point is significant, as it is evident that any expansion of services or improvement in the quality of care is dependent upon well-trained and adequate personnel. The advisory committees to the Children's Bureau believe that federal funds should be made available to the states for further training of all types of professional personnel, for the improvement of present training and for the development of new courses in centers of training that will integrate training in the fields of clinical medicine and public health.

The American Academy of Pediatrics will undertake with the Children's Bureau and the U. S. Public Health Service a survey in every state to determine the present situation relative to the distribution of children in rural and urban areas and to the personnel and facilities available and those that would be needed to meet the objectives now being set for the postwar period.

Tips on Selecting Books

KATHARINE E. MUFF
Librarian
Station Hospital
Camp Chaffee, Ark.

THE greatest hazard that besets the volunteer librarian is book selection. No matter how good her personal taste or how extensive her knowledge of books, without training or experience she will find it difficult to choose books to fit the needs of patrons as yet unknown to her. The hospital librarian has this problem intensified because her roster is always changing.

The problem can best be approached by asking not what but why people read. Many libraries have a large minority who read for information and self-improvement; schools have this group as a majority, but all libraries serving the general public find that most of their patrons read primarily for recreation and emotional release. This is particularly true in hospitals, since, naturally enough, even a serious reader relaxes when he is not at his best physically.

We all get a vicarious pleasure from reading about the elements of a full life that we consciously or subconsciously miss in our own. The young girl reads one simple love story after another, uncritically. A few years later she is bored by mushy books. When she is an old lady she will read them again. The man with the drabbest job and the least interesting environment will want the wildest books of adventure.

The degree of reading ability possessed influences the reader's choice of books. Volunteers frequently are puzzled because men who read Zane Grey novels reject other Westerns. Zane Grey has in a high degree what is called readability. Professional librarians judge books for readability so automatically that they are scarcely conscious of the rules they follow. One must look for lucidity, that is, it must be easy for the reader to grasp what the writer is talking about, if you are buying books for the Zane Grey contingent.

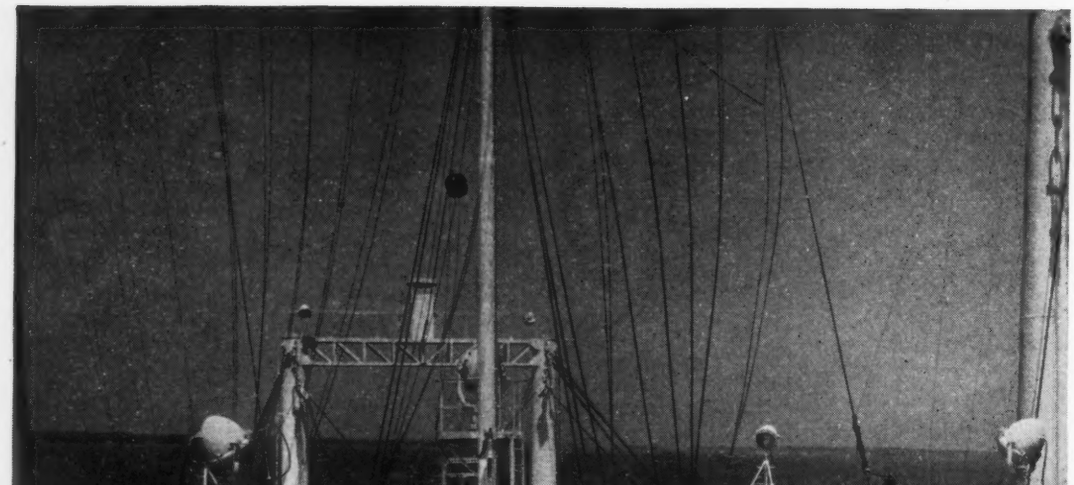
Familiarity of concept is another factor. If the ideas, as well as the vocabulary, are strange, the reader must make increased effort to gain comprehension. Appeal is difficult to measure but easy to recognize. The reader will absorb more readily that which he is eager to know. Simple, short sentences, easy words, simple progression of time, relatively few characters and much repetition of ideas mark the most readable book.

There Are Degrees of Readability

Faith Baldwin, Kathleen Norris, Louis Bromfield and Ernie Pyle are ready examples of such books. Your clientele may prove to have a higher percentage of capable readers but until that is made evident you must always keep readability in mind when you buy books. Of course, there are degrees of readability just as there are degrees of reading ability.

Books of humor are popular with all classes of readers. Morbid themes, death and disease and most psychological novels have no place in the hospital library. Detective stories, if well chosen, are acceptable. Otherwise, choose books for the sick and injured as you would for the well.

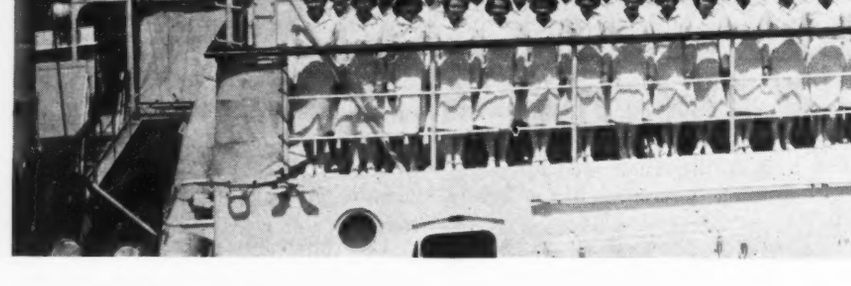
Don't be oversentimental about cheerfulness. Within the limits of common sense, forget that your patrons are patients. While they are seriously ill they will do little or no reading: when they begin to get well you can do your little bit toward hastening their convelescence by respecting their normal taste and mental abilities.



Left: The 30 young women who comprise the nursing staff of the "U.S.S. Tranquillity," one of the six new "Haven class" hospital ships. Below: The seven-deck, 520 foot "U.S.S. Tranquillity." Official U.S. Navy Photos.

Navy Hospitals at Sea

EVA ADAMS CROSS
Washington Representative, The Modern Hospital

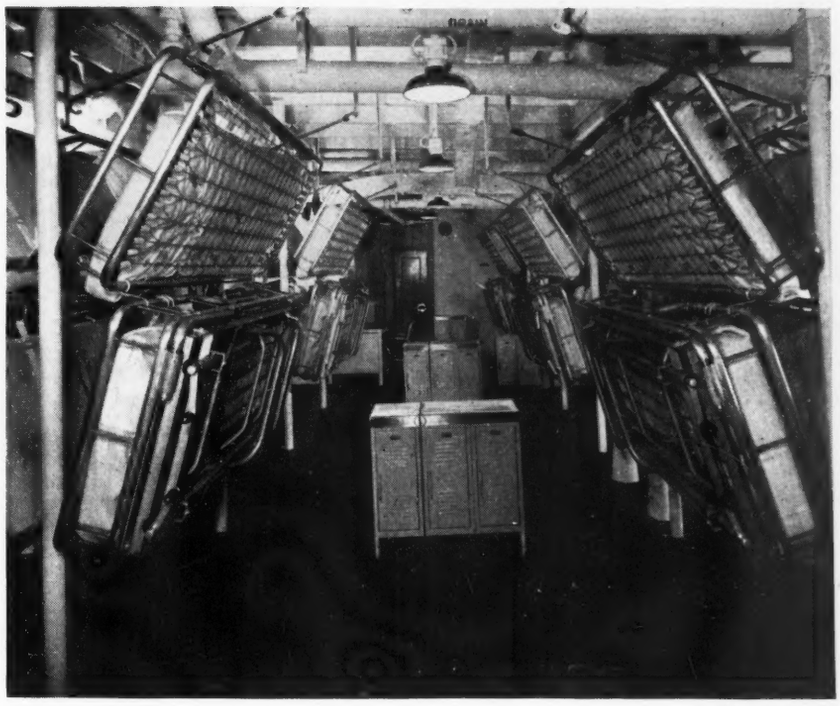


THE six new "Haven Class" hospital ships, the latest to join the Navy's mercy fleet, effect a compromise between the realities of ship design and the Bureau of Medicine and Surgery's vision of the ideal hospital ship. Many features employed in modern shore hospitals, as well as innovations not yet installed in any other type of naval craft, have been incorporated.

The 15,000 ton vessels are named the *U.S.S. Tranquillity, U.S.S. Haven, U.S.S. Benevolence, U.S.S. Repose, U.S.S. Consolation* and *U.S.S. Sanctuary.*

Chief among innovations in shipboard medicine is the location of clinical and surgical facilities deep in the hull and as near the metacenter, or roll and pitch center, as possible.

The operating and anesthesia rooms are fully protected against explosive gases through the use of sparkproof electrical outlets, vaporproof operating lights, electrically conductive decks and full air condi-



Medical ward of the "Tranquillity," showing how bunks are raised when they are not in use. Beds are provided for 802 patients and in an emergency the capacity can be increased.

tioning, with humidity and temperature control. All x-ray machines, both fixed and portable, are of the latest approved shockproof type.

The surgical suites include two admitting rooms for shock treatment and fracture rooms which contain orthopedic surgical tables especially developed to cover the full range of orthopedic procedures and to serve as general operating tables. Near the surgery section are central surgical supply rooms designed to permit a fast centralized service to the operating rooms and to the wards throughout the ships. The eye, ear, nose and throat department is equipped to serve as an auxiliary general operating room when necessary.

Dental clinics and laboratories have been developed to handle all phases of dental work, including prosthetic dentistry. A complete optical repair unit has been added to each ship.

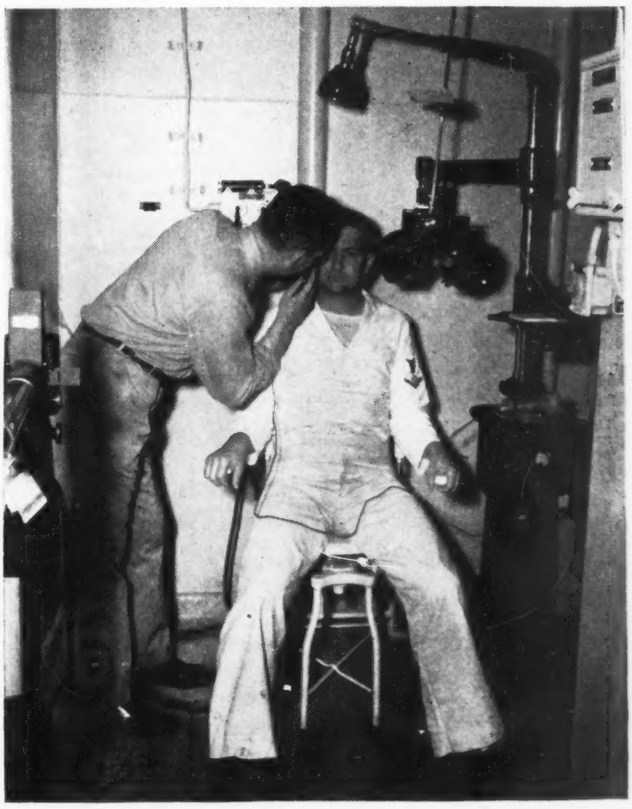
In the wards, decorated with cheerful color motifs and outfitted with fixed furniture of modern design, each berth has a five-channel entertainment broadcast system with ear phones and pillow phones. A master broadcast set provides long-wave and short-wave commercial radio broadcasts, two record turntables and a microphone for ship's programs. Off this circuit is a trunk system extending only to medical department spaces.

All of the ships have been so designed as to be of maximum service in forward assault areas, not only as fully equipped seagoing hospitals but as medical supply vessels. A total of 85,000 cubic feet of usable space has been provided in each vessel for medical storage. Stored here as a portion of the regular equipment is a complete field hospital of 100 beds in self-contained units which may be used by invasion or attacking troops.

Special emphasis has been placed on fitting out the ships with adequate equipment for handling battle casualties. New equipment includes four or six LCVP ambulance boats to eliminate, partially at least, the necessity for transporting wounded from beaches by means of rugged landing craft. The ambulance boats are unique in the battle scene. An increased number of accommodation ladders and hoists for litters and stores will improve embarkation and debarkation of patients.

Recreational facilities in each ship include ample spaces for lounges, movies, shows, deck sports and exercises, sun bathing and patients' libraries.

Slightly larger than the older type of hospital ships, the new auxiliary vessels are 520 feet overall in length, 71 feet 6 inches in beam, with a draft of 23 feet 6 inches. They have a cruising radius of 12,000 miles and a speed of 17.5 knots.



Eye Clinic of the "U.S.S. Haven." The most modern and complete equipment is available for examining and treating the eyes.

Quantity Is Not the Criterion *in estimating laboratory efficiency*

G. L. WILLIAMS
Detroit

THE number of examinations per specimen, the type of examinations done, the number of positive examinations, whether or not specimens are satisfactory or are properly requested must be considered in estimating the amount of work done by a laboratory. Other factors contributing less directly, such as skill and personality of the staff, administration, facilities, equipment and record system, have been considered in previous papers.[1, 2, 3, 4, 5]

Number of Examinations: Some of the factors influencing the number of examinations done per specimen include the laboratory director, the hospital staff, the adequacy and efficiency of the personnel and the section of the country in which the laboratory is located.

Some directors and some staffs consider advisable several instead of one serological examination for syphilis. With inadequate staffs work must be cut, reducing examinations. An investigative type of personnel often performs additional examinations. Parts of the country in which there is higher incidence of diseases producing antibodies are likely to do more serum agglutinations on a blood specimen sent in for typhoid.

The following data on state and city public health laboratories illustrate the variation in examinations done on specimens received. Texas (1939-40) performed 54,739 examinations on 33,317 specimens received (1.64 to 1) while the central branch of the New York State Laboratory (1940) performed 32,758 examinations on 30,408 specimens received (1.08 to 1). Baltimore (1939) and Washington, D. C. (1939) divided their laboratory data with the following results:

	Baltimore	*Washington*
Bacteriology		
Examinations	184,448	76,495
Specimens	85,938	66,857
Ratio	2.15 : 1	1.14 : 1
Chemistry		
Examinations	18,031	25,925
Specimens	7,474	15,274
Ratio	2.41 : 1	1.7 : 1
Serology (V.D.)		
Examinations	55,515	176,584
Specimens	55,515	74,848
Ratio	1 : 1	2.36 : 1

Unfortunately, certain laboratories confuse the terms "specimen" and "examination." One state (1941-42) records: "55,763 specimens were received from. . . . This represents a small increase over the 53,522 examinations made in the preceding fiscal year." Laboratories such as Georgia (1940) and Iowa (1938-40) record specimens while others (New York City, 1940, and Connecticut, 1942) record examinations.

Terms must be used in their true meaning. Material submitted for examination is a specimen from which a sample may be taken for one or more prescribed procedures or examinations. A single operation on a specimen, as one for albumen in the urine, is a test. At times there is only a single operation on specimens which then can be designated as a test or an examination, as a serological test or an examination for syphilis. The type and technic of the examination should be recorded, unless this is standard, to make figures significant.

Types of Examinations and Time Necessary: Table 1 gives the approximate time necessary to run various laboratory examinations in the hospital. Examinations taking the least and approximately the same time are taken as standard and given a value of 1. The time taken to perform other examinations are given values of 2, 3 and more according to whether they take 2 or 3 or more times the period necessary for the standard examinations.

Standard methods in making time studies were followed insofar as possible using representative personnel, conditions, numbers and types of examinations and technics ordinarily found in hospitals with a census of from 100 to 250 beds. Data accumulated in this fashion by other laboratory directors [6, 7, 8, 9] have been used as deemed fit. It is evident from the table that if the number of

The author wishes to thank John W. Williams, M.D., for furnishing data which made this article possible.

[1] Williams, John W.: How Many Examinations Should Be Made by a Laboratory Technician? Hosp. Mngt. **58:** 86 (Dec.) 1944.

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examinations were recorded, there would be no correlation with the work done in a laboratory doing predominantly long-time examinations and one doing predominantly short-time examinations.

The percentage variation from the mean of the number of time units per examination per hour of work for the months of each of the six month periods, beginning July 1, 1941, and ending Dec. 31, 1944, at an average general hospital doing approximately 35,000 examinations annually showed significant variation. In the interest of increased accuracy, coefficients of variation were computed using the standard deviation. Beginning July 1, 1941, the figure in percentage for each of the six month periods was: 51, 33, 22, 26, 45, 39.

The percentage increase of time units of work per hour of the most active month over the least active month for the years 1942, 1943 and 1944 was 64, 33, 37, and of examinations per hour of work, 56, 42 and 43. This again illustrates the lack of correlation between time units and examinations and stresses the advisability of estimating work done in terms of time units.

Factors Influencing Length of Time Unit: The time necessary for the collection of specimens, preparation for examination and examination varies. In computing units only such specimens as those for bleeding and clotting time, fragility of red cells and emergency blood counts were considered collected by the laboratory. Laboratories that collect the specimens should consider collection time as an individual item not charged to unit time.

Blood specimens for serological and chemical examinations take considerable time for preparation for examinations; others, as urine for routine urinalysis, take very little. The length of time necessary for preparation, as a rule, limits the possible time reduction with an increase in the number.

Influence of Number of Examinations on Unit Time: Specializing in a limited number of types of examinations and doing large numbers reduces the time necessary. The technical staff of the Boston Health Department laboratory, with examinations limited largely to bacteriology, milk and serology, and doing approximately 95,000 examina-

Table 1—Time Unit Values of Laboratory Examinations

Bacteriology	
Antibodies, tests for	
Heterophile	20
Hinton, Kahn, Kline	6
Rapid serology	10
Typing, pneumococcus	6
Wassermann	10
Weil-Felix	10
Widal, Para A and B	15
Autogenous vaccines	40
Cultures with microscopic	
Blood or feces	20
Fungi	20
Routine	15
Guinea pig inoculations	40
Microscopic organisms	
Dark field	15
Smear (except TB & GC)	6
TB smear and GC	10
TB smear with concentration	15
Blood	
Bleeding time	6
Clotting time	6
Counts	
Platelet	6
Reticulocyte	6
Red	4
White	3
Fragility test	20
Hematocrit	4
Hemoglobin (Haden-Hauser or Sahli)	3
Matching	4
Prothrombin time	16
Routine complete blood	15
Sedimentation rate (Cutler)	8
Smear	
Differential	6
Malaria	6
Typing	4
Blood Chemistry	
Albumin and globulin	15
Bromsulfalein	6
Calcium	16
Chloride	8
Cholesterol	10
CO_2	12
Congo red	6
Creatin and creatinine	10
Creatinine	6
Icterus index	4
NPN	6
Phosphatase	16
Phosphorus	8
Blood Chemistry (Cont.)	
Protein, total (falling drop)	4
Protein, total (Kjeldahl)	12
Sodium	16
Sodium chloride	8
Sugar	6
Sugar tolerance	15
Sulfa drugs	8
Takata Ara	10
Thiocyanate	10
Urea clearance	15
Urea nitrogen	10
Uric acid	6
Van den Bergh, quantitative	6
Vitamin C	8
Feces	
Benzidine	3
Parasites	
Ameba	6
Other	3
Routine	4
Gastric Contents	
Acidity only	8
Microscopic only	2
Routine	10
Spinal Fluid	
Albumin and globulin (Nonne-Apelt)	4
Count, cell	3
Gold, sol	10
Protein, total (Esbach)	2
Sodium chloride, quantitative	8
Sugar, quantitative	3
Urine	
Albumin, qualitative	1
Albumin, quantitative (Esbach)	2
Bence-Jones	2
Bile	1
Concentration (Mosenthal)	2
Diacetic acid and acetone	2
Galactose tolerance	6
Glucose tolerance	6
Hippuric acid	10
pH	1
Phenolsulphonephthalein	3
Routine	3
Sediment	1
Sugar, qualitative	1
Sugar, quantitative	3
Urobilinogen, quantitative	2

Table 2—Percentage of Unsatisfactory and Positive Specimens (1939-41)

	Unsatisfactory		*Positive*	
	Av.	*Range*	*Av.*	*Range*
Blood, syphilis	2.9	2.0– 3.9	*	*
Blood, agglutinations	3.2	1.7– 4.6	9.6	2.0–20.9
Brain, rabies	13.7	3.1–37.0	28.9	23.6–36.5
Cultures, diphtheria	5.1	1.8–12.0	10.2	3.7–16.7
Feces, culture	4.8	0.7–12.0	9.3	7.1–13.3
Smears, gonorrhea	1.8	0.4– 3.4	16.5	7.9–23.4
Smears, malaria	10.5	0.0–38.0	5.4	3.1–10.0
Smears, tuberculosis	2.3	0.5– 4.0	24.7	8.8–59.9

*See publications of Venereal Disease Division, U. S. Public Health Service, for complete studies on this subject.

tions in 1941, performed 35 units per hour of work.

The hospital laboratory referred to previously averaged 30 units of clinical pathology per hour of work between July 1941 and December 1944. The former laboratory required more clerical help. If all help was included each laboratory performed approximately 25 units an hour of work. The larger amount of work required in the Boston laboratory for the preparation and mailing of containers and results of examinations added sufficient labor of operation to cancel the shorter time necessary for individual examinations. Detailed study of this problem is necessary.

Positive Specimens: Table 2 illustrates the variation in the percentage of positive bacteriological examinations in four public health laboratories. With a larger number of positives, the average time of diagnosis usually is reduced, since search can be discontinued more quickly.

Unsatisfactory Specimens: Table 2 illustrates the percentage of unsatisfactory bacteriological and serological specimens in four public health laboratories. Unsatisfactory specimens increase the work. By tabulating and posting unsatisfactory specimens the number of unsatisfactory blood specimens of one laboratory was reduced from 7 to 1.5 per cent.

Improper Requests: By posting these figures the number of incomplete and inaccurate requests was reduced in one laboratory from 20 to 2 per cent. While details of omission can often be ascertained by inquiry, confusion and added work result.

Summary: Specimens received by a laboratory are not an index of the examinations or the work done. They are an index of patronage.

It is necessary that all laboratories use terms such as specimens, examinations and tests in the same sense.

The unit of time of various types of examinations should be used to determine the work done. This will vary somewhat in different laboratories for the reasons stated and should be adjusted accordingly.

Standardization of the methods of estimating the work of a laboratory and the terms used by the laboratory are important as points of departure in establishing more efficient function and better policies.

SMILE *When You Say That*

J. MILO ANDERSON
Superintendent, Methodist Hospital, Gary, Ind.
Formerly, Assistant Superintendent, University of Chicago Clinics

SOME time ago the University of Chicago Clinics sent questionnaires to a group of patients who had been treated both in the outpatient department and in the hospital. The response was good but the percentage of patients who had no complaints was so high that we suspect that the questions were not worded in the correct manner. The questionnaires were to be returned unsigned but a few patients signed their names.

The unfavorable reactions and the suggestions for improvement were tabulated and, as is usually the case, not one was concerned with medical care. The time spent waiting for doctors, x-ray examinations and laboratory work was the commonest criticism. Uncomfortable chairs, too little personal attention and the feeling that the patient was "a number" rather than an individual were other complaints.

There Is Room for Improvement

The suggestions received through these questionnaires concerned conditions that could be easily improved. It was decided to give our key people some training in public relations. We chose for the first group those employes who were constantly in contact with patients. These included admitting officers, clinic secretaries, cashiers, business office personnel and information clerks. They made up a group of 35.

Ten classes were planned which met from 5 to 5:45 p.m. once a week for ten weeks. Attendance was obligatory but it was explained that the classes would close promptly and that each person attending them would be given a day off to make up for the time that had to be spent in class.

The Bacon Library of the A.H.A. sent us a large package of material dealing with public relations. Copies were made of the articles we could use and were distributed to everyone attending the course. We engaged a firm that was doing public relations training in industry and its services were valuable in outlining a program and in getting material together for teaching.

Superintendent Attends Session

To stress how important this program was considered by the administration, the director of the clinics attended some of the classes and the superintendent attended all of them. The director opened the first meeting with a short talk emphasizing what an important part that group played in improving the service and enhancing the reputation of the institution.

His talk was followed by a film, "Guests Are Coming," which was made for a retail sales organization. This film cleverly pointed out how much customers in the department store are like guests in the home. The rest of the first period was spent in discussion fitting the picture into hospital problems.

The second class began with a short talk by the superintendent reviewing the previous meeting and again stressing the importance of the group in personalizing our service to patients. The first fifteen minutes in an institution either "makes" or "breaks" that institution in the eyes of the patient. In all these meetings we carefully stayed away from teaching the mechanics of doing the routine work of the hospital. Public relations was the sole subject discussed.

The rest of the second session was filled by discussion in which the members of the class could ask ques-

Hospital service is only as good as the patient thinks it is, and what the patient thinks is likely to be based on the degree of friendliness that he encounters among the people with whom he comes in contact

tions of the superintendent or one another. Specific cases were discussed —how they were handled and how they might have been handled better.

Franklin's Rules Still Good

Another film, "Selling America," based on the autobiography of Benjamin Franklin, opened the third session. Benjamin Franklin brought out five cardinal rules of conduct in his book. Brought up to date they are:

1. Get the customer to talk; ask questions.
2. Don't argue.
3. Don't contradict; don't be too positive.
4. Answer with a "Yes, but—."
5. Don't waste time but tell a complete story.

Discussion of this film relating it to patients rather than to customers filled the remainder of the meeting.

The fourth meeting was opened by a short talk given by the director of admissions emphasizing the importance of first impressions. In our organization a patient on his first visit ordinarily sees six persons before he reaches a doctor. The appointment clerk, the admitting officer, a volunteer, the cashier, the laboratory technician and the clinic secretary all must know how to sell the hospital through good public relations or this "red tape" can become extremely tedious. Discussion based on the film of the previous session followed.

Each member of the class was urged to bring examples from her own experience but because of fear either of criticism or of the appearance of boasting, only a few were submitted. We had a supply of actual cases which we presented and asked various members of the class how they might have been handled better.

The importance of group discussion cannot be overemphasized; however, it must be kept going at a lively pace. If discussion drags, the leader must be prepared to vary the program in order to sustain the interest of the class.

The superintendent of the clinics spent most of the fifth class period discussing the answers to our questionnaires. Some were read in full and members of the group could recognize the episodes described. A lively discussion filled the period which had to be stopped at 5:45.

A local bank lent us a film "They Come Out Smiling," which was shown at the sixth session. Because a large bank has many departments and many routine procedures, its problems in many instances are similar to those of a hospital. By examples, many of them ludicrous when demonstrated but common in practice, five points were made:

1. Don't keep people waiting needlessly.
2. Don't confuse them with technical terms.
3. Watch expressions on customers' (patients') faces to see if they understand directions.
4. Call the customer (patient) by name.
5. Smile. Ask "May I help you?"

This motion picture was so apt that it might have been made for a hospital.

Classes 7, 8 and 9 were given to consideration of telephone manners. The bank lent us another film, "Sound Business," which visibly and audibly demonstrated 13 common errors in the use of the telephone.

For the eighth meeting, the Illinois Bell Telephone Company sent a representative who talked about telephone etiquette and presented a picture, "The New Voice of Mr. X," which showed what a great difference a careful study of one's telephone manner, voice and inflection makes to the person on the other end of the wire. Booklets on telephone etiquette were given to all members of the class and we were all given an opportunity to talk into a "voice mirror," an instrument that plays back what has been said into it. Most of us were surprised at how our own voices sounded on the telephone.

Meeting No. 9 was given over entirely to discussion of cases, most of them actual. By this time the entire group was more aware of the purpose of these discussions and took part enthusiastically.

A sort of final examination was given at the last meeting. A numbered list of the points brought out during the course was posted on the blackboard. Several interviews and conversations were presented and the class listed (by number) the defects in them.

Results Almost Too Good

The results of this program were evident immediately. Patients were pleased by the pleasant way they were handled and took the trouble to tell us. Members of our medical staff found their patients in a mellower mood. In some respects the results were too good. Many of the girls trained were pirated from us, some by doctors on our own staff, some by other physicians. A visitor even tried to hire one of the information clerks on his first visit to the hospital. One girl was offered another job over the telephone.

The members of the class themselves found their work pleasanter and took pride in telling of some incidents which might have been disagreeable but which they could now handle nicely.

Hospital service is no better than our patients think it is. This means that in most instances it is not the competence of the staff or the excellence of the laboratories by which we are judged. We are more likely to be commended or condemned because of the things the patient can see and understand.

The friendly smile, the kindly attitude, the pleasant voice and the general spirit of confidence in the institution—these are the most important bases upon which good public relations can be built. Most employes have or want these qualities. All that is necessary is to teach them how to acquire and use them. This can easily be done and it pays dividends far in excess of the effort involved in doing it.

Intravenous Service Centralized

to everybody's satisfaction

FRANK C. SUTTON, M.D.
Assistant Medical Director
Rochester General Hospital
Rochester, N. Y.

WHEN parenteral fluids were first introduced in hospitals, their use was limited principally to patients in extreme states of dehydration who were incapable of tolerating fluids by any other route.

The parenteral fluids then given were essentially limited to distilled water and solutions of sodium chloride given in small amounts. Because of possible hazards involved, administration of these fluids was assigned to the intern who was assisted by the nurse. The intern was required to observe the patient for any unfavorable reaction throughout the period in which fluids were being administered.

Since the introduction of parenteral fluids, few therapeutic procedures have shown such remarkable growth. With advances in knowledge of this therapy, parenteral fluids are now being given subcutaneously, intramuscularly and intravenously not only as a prophylactic measure to prevent surgical shock but for a variety of other indications. With accumulated experience technics were modified so that parenteral fluids are now administered by the intern with nurse assistance, the function of observing the patient and discontinuing fluids being generally assigned to the nurse.

The range of fluids used has been extended to include hypotonic, isotonic and hypertonic solutions of sodium chloride and glucose; buffer solutions, such as Hartman's and Ringer's, and, more recently, amino acid preparations, heparin, water soluble vitamins and the sodium salt solutions of the sulfa drugs and penicillin. In addition, the quantity of such preparations now used is much greater than was originally considered necessary. In Rochester General Hospital (323 beds), 9165 flasks of parenteral fluids were administered during the year 1944.

Under such conditions it seemed justifiable and desirable to consider relieving the intern and general duty nurse of the task of administering parenteral fluids. Of immediate importance, in view of a depleted nursing staff, was the possibility of saving valuable nursing time spent in assisting the intern in this function, thus freeing the general duty nurse for other essential nursing duties. It was felt, too, that this function, once an instructive feature of house officer training, had become a routine hospital service without essential educational value to the intern.

Since a similar historical background applied to the administering of blood and plasma transfusions and (in some hospitals) to the collecting of morning blood specimens for the clinical laboratory, the reassignment of these services was also regarded as desirable. In contemplating the possibilities of reassignment, the convenience, efficiency and time-saving features of a centralized service were favorably considered.

As a result there was recently established at the Rochester General Hospital a branch of the central supply department known as the central intravenous service, utilizing a graduate nurse to administer both parenteral fluids and nonemergency blood and plasma transfusions and to collect morning blood specimens for the laboratory. Until additional personnel is available, this service is provided between 7 a.m. and 3:30 p.m. daily except Sunday throughout the hospital, except in the pediatric, obstetrical and emergency departments, and in the operating rooms where existing personnel is immediately available to render such services.

The nurse makes her rounds with her cart set up with all of the needed equipment and supplies.

Operating as a portable branch of central supply, the service is established as a self-contained unit, parenteral fluids, syringes, needles and other necessary supplies being carried on a surgical cart by the intravenous nurse on her rounds of the floors. No advance preparation or assistance by the intern or the nursing staff on the floors is necessary. A student nurse is usually assigned to accompany the intravenous nurse on each floor to observe the technics of this service as a part of her training program.

Requisitions for central intravenous service submitted to central supply on the preceding evening permit the arrangement of an orderly working schedule each day, in which laboratory blood specimens are obtained on the floors between 7 a.m. and 9 a.m. and parenteral fluids and blood and plasma transfusions given between 9 a.m. and 3:30 p.m.

Upon completing her duties on each floor the intravenous nurse, or assigned student nurse, makes an entry in the nurses' notes section of the patients' records, indicating the time and nature of the service rendered in each case and notifies the head nurse who, from that time, is responsible for providing proper observation of any recipient patients. The intravenous nurse is notified and corrects any difficulty encountered during the period of administration of fluids, blood or plasma. Empty solutions flasks and used equipment are returned from the floors to central supply daily by aides.

For emergency service the intravenous nurse may be reached

through the vocal paging system, such requests being limited mainly to parenternal fluids for patients returning to the floors from the operating rooms. By scanning the operating room schedule daily, the intravenous nurse anticipates most of these calls. During hours when the intravenous nurse is not on duty and in departments in which her services are not provided, such services are performed by the intern with nurse assistance, as previously.

Members of the medical staff are unanimous in their approval of the manner in which this service is conducted. Relieved of a significant portion of his daily assignments, the intern is now able to spend more time in attendance at necropsies and with other educational activities.

An improved student nurse training in the technics used by the central intravenous service is now provided by reason of a more orderly daily schedule for observation and the use of uniform standardized technics.

Nothing in this report is intended to belittle the hazards which are known to accompany the administration of parenteral fluids or plasma and, particularly, citrated blood. However, many leading surgeons and internists agree that it is no longer necessary to require the intern personally to perform this service, provided a substitute is assigned who is properly trained and well aware of the potential hazards involved. It is my belief that a graduate nurse fulfilling such requirements could properly supervise a central intravenous service with a staff of one or more carefully selected and trained technicians.

Cancer Research Spurred On

NEW impetus, and new hope of success, in the war against cancer was given by the announcement on August 8 by Alfred P. Sloan Jr., chairman of General Motors Corporation, of a gift of $4,000,000 from the Alfred P. Sloan Foundation to provide and, in part, to maintain the projected Sloan-Kettering Institute for Cancer Research.

The research foundation will be organized in conjunction with Memorial Hospital for the Treatment of Cancer and Allied Diseases in New York City.

The specially designed research building, to be erected at a cost of approximately $2,000,000, will be located on property now owned by Memorial Hospital adjacent to its present location. The facilities to be provided will be adequate to permit the exploration of all avenues that may be expected to contribute to the objective.

In addition, the Alfred P. Sloan Foundation will undertake to provide $200,000 a year toward the operating cost for a definite period of ten years. It is hoped that other persons interested in the same objective be persuaded to provide additional financial support.

The contribution of Dr. Charles F. Kettering, vice president and director of research for General Motors, will, in his words, "be largely to help supply the general types of technics long employed in industrial scientific research. All this must be done through the medical profession to help accelerate the work upon this dread disease."

Architect's drawing of the proposed Sloan-Kettering Institute. Skidmore, Owings and Merrill. have been named as architects.

Discussing the application of the research technics of modern industry to health problems, Doctor Kettering pointed out that "down through the years we have developed certain research procedures that have proved to be amazingly versatile in their applications. There is a good chance that we can advantageously apply some of these methods to uncovering some new facts about this disease that yearly takes such a heavy toll of human life. If we can turn up something new in this field and the medical profession can use it in its courageous fight against cancer, this will be ample reward for any effort we put into the undertaking."

Mr. Sloan, in commenting on the proposed project, stated that the determination of the cause of cancer is one of the great unsolved problems of mankind. He added:

"Any attack on such a problem must be a relatively long-term one. It requires the highest standard of scientific talent supported by adequate facilities, as well as time. The resources being made available to the new institute will permit planning a ten year program of maximum intensity with the assurance that it can be carried through to completion. . . . In addition to this specific project we hope it may be possible to organize on a high scientific level the more complete coordination of other worthy efforts now being directed to the same end.

"Our association with Memorial Hospital is, I believe, most logical. Memorial specializes exclusively in the treatment of cancer. It has a broad background of years of experience and a high standard of accomplishment. Likewise, it is already an important factor in cancer research. Its present research facilities and personnel will become a part of the newly created institute."

The institute, it was explained by R. G. Coombe, president of Memorial Hospital, will "stand squarely in the middle of Memorial Cancer Center," but it will be operated by a separate board of trustees composed of men primarily interested in research. The funds that will be entrusted to the board can be used for no other purpose. As an integral part of the center, all of the clinical facilities and material of the other units will be available to the institute.

The Clergy Learn About Hospitals

at the Institute for Pastoral Care

INA MAY GREER
Boston

WITH the greater emphasis that has been placed within the last few years upon the fact that a patient is a sick person, not merely the possessor of an ailing organ, an identified infection or an injured limb, has come a greater emphasis upon treating him as an entity, a whole human being who possesses both psyche and soma, both of them interrelated and both interacting.

With such an orientation have appeared a new concept of the rôle of the hospital chaplain and a new set of demands and standards arising not only from what the hospital needs but also from his own vision of the meaning and scope of pastoral care.

Medical, Clerical Fields Overlap

Both physician and clergyman have come to see that at many points their fields overlap. They often meet in the sickroom. Both have to deal with the serious crises of life: birth, death, sickness. Both have to take into account the patient's faith and will to live.

Out of this matrix have emerged organized attempts to fit men to fulfill hospital and parish needs. One of them, the Institute of Pastoral Care, organized in 1944 at Massachusetts General Hospital, Boston, and headed by the Rev. Rollin J. Fairbanks, has as its avowed purpose the organization, development and support of "a comprehensive educational and research program in the field of pastoral care, with special reference to the sick, using the opportunities offered by clinical training as a primary means to this end."

The institute and its program grew out of the pioneering efforts of Dr. Richard C. Cabot and Rev. Russell L. Dicks and is but a further elaboration and refinement of the work that has been done in the hospital since 1933.

Throughout the year brief seminars are offered accredited students in theology and parish clergy who are seeking to orient themselves in modern concepts of physical and mental disease. In large measure, the lectures are given by members of the hospital staff.

During the summer two more intensive courses are offered of six weeks each, the one open to theological students and young clergymen who have had less than three years' experience and the other to older men who wish to know more about handling certain parish problems and to broaden and sharpen their pastoral technics.

Although students may obtain academic credit for the courses and apply it toward their graduation from associated seminaries, the institute is nonsectarian, without creedal bias, and is guided by a board of governors made up of physicians, clergymen, educators and interested laymen.

During the first two weeks of the summer courses half the eight hour day is devoted to volunteer orderly service. After a minimum of training, each man is issued a white coat and assigned to a ward, where he is expected to do the work of any orderly.

At the end of two weeks he ceases to function as an orderly and becomes a chaplain-in-training. Certain carefully selected patients are assigned him. He continues to attend lectures on medical, psychiatric and social service topics given by members of the hospital teaching staff and is taught the aim and technics of counseling. He sees an anesthetic given, watches an operation, attends a postmortem examination, listens to at least one clinicopathological conference and visits a medical or surgical "grand round." He has access to a reference library and is furnished a list of assigned and recommended books.

Most of the time is devoted to supervised visiting on the wards and recording, discussing and evaluating these visits. Sometimes he goes alone. At other times he is accompanied by an older chaplain and the two share the interview, each observing and criticizing the other. Most important are his notes. The student is expected to record each interview, not in general terms but according to a planned outline.

First, he must list his preliminary data: the age of the patient, his civil status, sex, home address, admission date, ward, diagnosis, source of referral, assigned social worker, faith.

Next comes his plan for the interview: what he hopes to accomplish. Then follows his impression: a sketch of the patient as he appeared at the beginning of the interview, and his report of the pastoral call: a detailed, verbatim account of what occurred during the visit, what each said, the pauses the patient made, his smiles, grimaces, interruptions, shifts of subject.

Summarize Results

Then comes the summary: an analysis of the interview and the problem as it is perceived, the interpretation of the subject matter, relationships, insights and understandings gained by the student, a critique of the methods used, both satisfactory and unsatisfactory, and an evaluation of the pastoral opportunities presented by the interview whether they actually appeared during the visit or are merely anticipated for the future.

Last comes a plan for the next call: what is proposed for the next visit, the specific things to be accomplished, possible means of doing so

and any pitfalls that should be avoided.

These notes are submitted to one of the teaching staff, who reads them, makes marginal comments and suggests possible lines of action. Two hours of each day are devoted to a seminar in which the notes and their relation to general parish problems are discussed. These meetings are true seminars with each member taking part in the discussion and learning from his own mistakes and from those of his fellows.

From their responses, both while they are in the work and after they return to their parishes, the students are enthusiastic and convinced of the value of their course. The hospital also gains, not only from the aid given the patients and the easing of certain nursing problems but also from access to a supervised ministry which takes into careful enlightened consideration the diagnosis, prognosis and selected medical treatment of the patient.

Prognosis Favorable:

for New Jersey's Chronically Ill

EMIL FRANKEL
Division of Statistics and Research
Department of Institutions and Agencies
Trenton, N. J.

DURING the last decade or so an ever-increasing interest has been manifested in the problem of the chronically ill in New Jersey. The way was paved by a legislative commission working in close cooperation with the New Jersey State Department of Institutions and Agencies. Its research findings were embodied in a "Report on Chronic Disease in New Jersey" outlining the essentials of a program for the care of the chronically ill.

Subsequently, the Governor's Health and Welfare Conference gave renewed consideration to this problem, as did the division of medicine and inspection of private institutions of the State Department of Institutions and Agencies.

Over the years various state and local health and welfare groups likewise have studied this problem and, more recently, the New Jersey Hospital Association has asked its welfare committee to study the present facilities for the care of the chronically ill in New Jersey and the setting up of a program that will meet the growing need for this type of care.

Existing Provisions Reviewed

Pending future detailed studies which the welfare committee is planning to make in cooperation with other health and welfare organizations, private and public, it is reviewing existing provisions for the care of the chronically ill and the trend they should take more fully to meet the growing problem of chronic disease.

In a statewide survey of hospital facilities made some years ago it was brought out that the general hospitals of New Jersey were usually ready to treat patients who are chronically ill; yet it was felt that the care of such patients is a special function and that specially equipped institutions should be made available for their treatment.

A few general hospitals reported special provision for chronic disease patients by designating certain sections for them. On the whole, however, it was difficult in most of our communities to obtain hospital care for a patient with chronic disease who is indigent or who cannot afford to pay general hospital charges. Some general hospitals did not accept chronic cases and others admitted such cases reluctantly even though the patient was able to pay the regular fees.

The situation with regard to the general hospital has not changed essentially since the survey was made. There is a growing feeling, however, of the need for some more definite action and considerable discussion among hospital administrators as to the most appropriate methods to be adopted. This discussion is exemplified by two schools of thought: the one advocating a separate and distinct hospital for chronic diseases; the other, special facilities for the chronically ill within the existing general hospitals.

In this connection the views of Dr. Ernst P. Boas and Dr. E. M. Bluestone are being given thoughtful consideration. Doctor Boas has long advocated the creation of a hospital for the chronically ill, conceived as "a hospital with every modern appliance for the treatment of the chronic sick in a homelike atmosphere." He points out "that the construction and organization of a hospital for chronic diseases have not the same foundation of traditional experience that has brought to a certain degree of standardization the basic architectural and administrative features of general and of many special hospitals."

Patients Fall Into Three Groups

In the special chronic disease hospital the patients, according to Doctor Boas, would be classified into three groups: (1) those who need active medical care for diagnosis and treatment; (2) those who need chiefly skilled nursing care, and (3) those who need only custodial care.

Quite a contrary view is taken by Doctor Bluestone, an intrepid advocate of the cause of the chronically ill. He strongly feels that "the long-term patient still requiring intensive medical care is far more closely related to the 'acute' general hospital than he is to the custodial institution, although he sometimes occupies

a medical position midway between the two."

Doctor Bluestone suggests that long-term patients should be treated in the general hospital as overflow in separate wards, pavilions or other hospital units, since the chronic disease patient requires every facility of the general hospital, plus certain additional facilities for his care, such as more physical therapy, occupational therapy and rehabilitative therapy.

The views of these two schools of thought undoubtedly will find accommodation to each other, for in the long run it would seem that both methods of care of the chronically ill —general hospitals and specialized hospitals for chronic disease—will be needed and both will be developed simultaneously in accordance with the existing situation in local communities.

Nursing homes of high standards fill a real need in the care of the chronically ill and their continuous development is an important factor in providing the needed facilities for the growing number of chronic disease patients.

It is important, however, that such homes be licensed and subsequently inspected by a state authority. In New Jersey an application for license to the State Department of Institutions and Agencies must be accompanied by written approval from the municipal authorities (fire, health, zoning and building departments) indicating that they approve the location and structure as safe and suitable for the purpose of a nursing home. The financial credit of the applicant must also be vouched for.

Good Standards Maintained

Subsequent supervision makes certain that the licensed nursing homes maintain reasonable standards of equipment and internal administration and operate under a clear understanding with the division of medicine and inspection of the private institutions of the department as to the type of patient who may be accepted for care, the number and limitations as to the housing and standards of housekeeping and professional care expected.

The local welfare homes (fortunately referred to less and less as almshouses) at the present time still are an indispensable link in the chain of institutions caring for the indigent chronically ill. These homes are among the oldest of our institutions caring for the indigent. They gradually have come to realize that the majority of persons admitted for care are essentially the chronically ill and accordingly need medical treatment prescribed in accordance with their infirmities.

Various steps have been and are being taken by the Department of Institutions and Agencies to encourage the conversion of the welfare house into an infirmary for the care of the chronically ill and the department recognizes the importance of awakening the local community to its responsibility in this connection. Today, for example, such recently constructed welfare houses as those in Monmouth and Burlington counties include hospital sections devoted to the care of the chronically ill.

In Passaic County, a complete medical program is carried on at the Welfare House. In Morris County the aged chronically ill receive sympathetic care in an antiquated structure which has been thoughtfully modernized. Middlesex County also has undertaken to convert an institution formerly used as a custodial type of welfare house into a county institution for the chronically ill.

The large number of recipients of old age assistance, with accompanying physical and emotional difficulties, has focused attention on the need of developing special medical and nursing services for the aged. Comprehensive local arrangements have been made for appropriate medical services including those of physicians, nurses, pharmacists, hospitals and other institutions.

A recent study made by the state department that gives financial aid to municipalities for their general relief expenditures revealed that approximately three fourths of the present recipients of local assistance are classified as "long-term dependents" and the predominant and underlying cause of long-term dependency, aside from old age, is chronic illness associated with physical and mental disability.

The great proportion of this group is in need of public aid primarily because of chronic illness or disability in one form or another. The nature of the diseases, the fact that many are physically handicapped and the seriousness of the physical or mental breakdown preclude the possibility of either immediate or extensive rehabilitative measures that would remove these cases from the local rolls.

Various remedies have been suggested by the municipal aid division for general care of chronic disease patients and to meet the special needs of cancer and cardiac cases. The division remarks that "postwar plans which take into account these needs will have a two-fold effect: (1) employment through the construction of necessary public institutions, and (2) improvement in our social welfare services. Mobilization of public opinion and molding of that opinion should not be difficult."

Cancer Is Public Health Problem

Cancer is recognized more and more as a public health problem of great importance, and there is also a growing recognition that facilities for the adequate care of cancer patients, based on the minimum standards of the American College of Surgeons, need to be greatly developed in New Jersey.

Education, which involves the advancement and dissemination of knowledge regarding cancer among the general public, is actively carried on by the New Jersey field army of the American Cancer Society which is gradually extending its organization throughout the 21 counties of the state.

In surveying the situation at the present moment, the welfare committee has the feeling that we in New Jersey are on the road to recognizing the special needs of the chronically ill as we have previously recognized the special needs of the mentally ill, the epileptic and the tuberculous.

Slowly the various health and welfare organizations are recognizing the care of the chronically ill as their special function and are beginning to adjust their programs and facilities to meet the needs of these patients.

It may be true that the general public has as yet no deep understanding of the signifiance of chronic illness. A definite and cooperative program of public education therefore is indicated so that the extent and urgency of the problem will be fully recognized and the facilities fundamental to a comprehensive program of care and prevention will be made available.

Electron Microscope

New Tool for Research

D. G. SHARP
Associate Biophysicist, Department of Surgery
Duke University School of Medicine, Durham, N. C.

MEDICAL science has made much progress toward the conquest of bacterial diseases and of diseases caused by other minute organisms. In this progress the light microscope has played an invaluable rôle, one which, through long practice, has become commonplace and routine.

This was not so, however, in the instance of another great group of infectious agents, the filterable viruses, which are too small for visualization in the ordinary light microscope. For many years workers could observe only the results of the widespread pathologic activities of these agents in man, animals and plants.

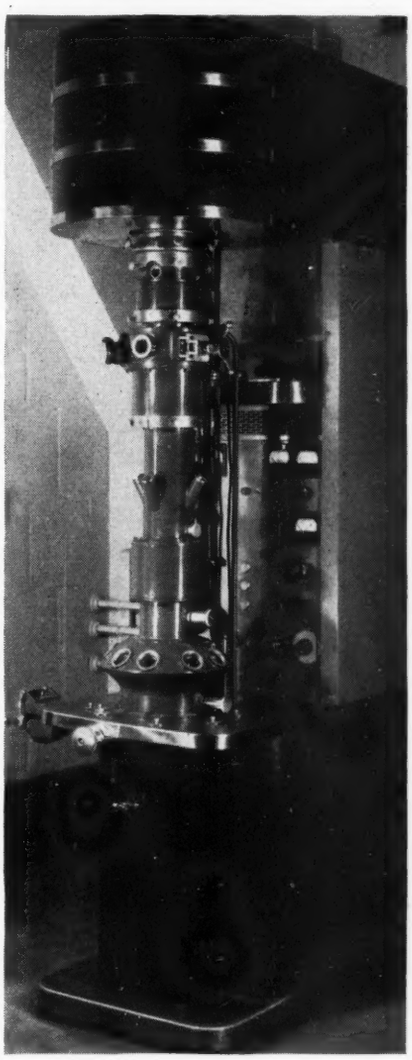
Now, through use of the electron microscope, these tiny particulate entities have been withdrawn from their obscurity in diseased tissues and exposed to visual and photographic examination. The electron microscope has extended the frontier of the visible to these and other objects as much as 100 times as small as those that could be seen before. This has been accomplished through the use of electrons instead of light photons for image formation and photography.

Light Microscope Limited

The ability of the light microscope to distinguish or *resolve* minute objects is limited by the wavelength of light, which is intimately related to the photon energy and color of the light used. No matter how carefully the glass lenses may be ground, this limit cannot be exceeded.

When it was learned a few years ago that a beam of electrons moving at high speed, which was attained by its passage through a region of high voltage, could be controlled in regular spirals through a magnetic field and brought to focus to produce images, the electron microscope became possible. Instead of glass lenses, magnetic coils are used; in the place of glass object slides, collodion films supported on fine-mesh wire screens are substituted, and instead of a limit in resolving power, arbitrarily established in the case of the light microscope by the light itself, it is possible to vary the electron energy at will by varying the accelerating voltage.

While this last condition practically removes from electron optics the resolving power limitation which hampers further development of the light microscope, certain other difficulties are increased. It is not yet possible, for instance, to produce magnetic or electrostatic lenses of the high degree of perfection possible for light lenses. Nevertheless, a sufficient number of these problems have already been solved to make the new instrument a valuable and entirely practical research tool.



The new microscope has extended the frontier of the visible.

The electron microscope is essentially an electron or cathode ray tube into which can be inserted the object and a photographic plate, and out of which the air can be pumped to allow for the unobstructed movement of electrons. Suitable controls are provided for movement of the mounted object and camera plates and a fluorescent viewing screen is provided, which operates like a reflex camera, sliding or tipping out of the electron beam when a picture is to be made.

Images Similar to X-Rays

The images visible on the fluorescent screen are similar in many ways to those seen in the x-ray fluoroscope. Electron pictures, too, are more like x-ray pictures than like those made with light. This is of importance, for the staining technics commonly used with bacteria are of no value in electron micrography.

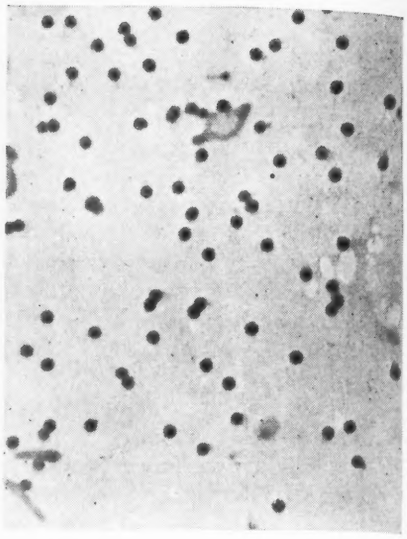
As in radiography, color has no meaning in electron micrography, but processes analogous to the application of radiopaque substances to increase contrast of specific organs have been used to increase the visibility of some viruses and to bring out structure within the bacterial cell.

In the fields of medicine and biology, a most gratifying use of the electron microscope has been made

in the direct visualization of certain of the viruses causing disease in man and animals and in plants. The value of the instrument for this purpose, not only from the point of view of the satisfying portrayal of hitherto invisible entities but in the enormous saving in time and labor, is difficult of description.

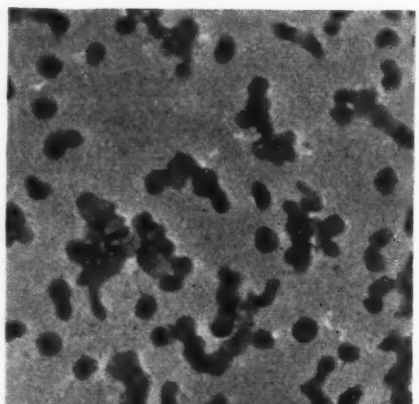
Animal viruses range in size from about 0.010 μ for the agent of poliomyelitis to 0.250 μ for that of vaccinia. Some of the larger viruses are just visible in the light microscope when treated with special strains or examined in the dark field with the ultramicroscope, but it remained for the electron microscope to produce pictures of these important pathogens that were large enough and clear enough for critical study.

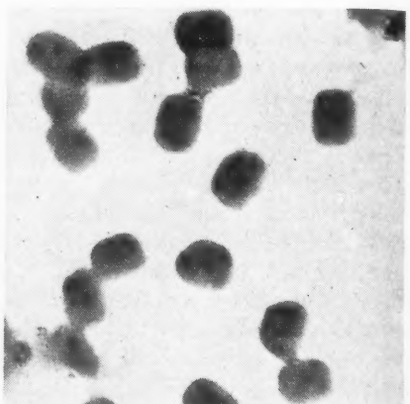
The results of the application of the instrument in this field are illustrated in the accompanying electron micrographs of tobacco mosaic, equine encephalomyelitis, influenza A and vaccinia viruses. The degree of magnification in these micrographs is the same, namely 30,000 x. The problems of size, shape and other aspects of the morphology of viruses are of paramount importance and most difficult to investigate when the particles cannot be seen. Such questions are resolved with simplicity, however, with the electron microscope.



Above: Tobacco mosaic virus. Below: Human influenza A virus.

Above: Equine encephalomyelitis virus. Below: Vaccinia virus.





Striking Differences Revealed

Micrographs of the virus particles reveal striking differences in the morphological characters of the various viruses, despite their small size. The tobacco mosaic virus is a long, slender rod 0.015 μ thick and about 0.200 μ in length. The viruses of equine encephalomyelitis and the rabbit papilloma, about 0.040 μ in diameter, appear to be spheres of remarkable uniformity in size and shape.

In contrast are the viruses of influenza A and B of man and the swine influenza virus, which vary widely in size and are roughly spherical or bean-shaped. The average diameter of the influenza virus A particle is about 0.100 μ. The vaccinia virus appears to be a short rod of about 0.260 μ in length.

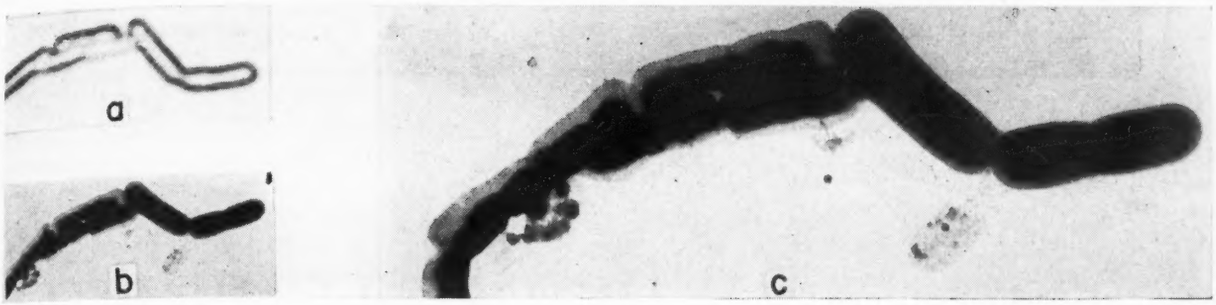
In all of the animal virus particles there is clear evidence of internal structure seen as a region of density greater than that of the remainder of the particle. Morphologically these virus particles have the appearance of minute organisms with evidence of analogous intraparticle distributions of nuclear and of cytoplasmic material.

In addition to the knowledge of the shape, size and other characters of these viruses as revealed in the electron pictures, it is perhaps of equal importance to be able to estimate the degree of purity of partially purified virus preparations. Preparation of large quantities of pure virus is one of the prerequisites to exacting chemical and physical studies of the viruses.

In such work the bacteriologist is greatly aided by the light microscope and in similar work with viruses the research worker is similarly aided by the electron microscope. Progress in virus research has been and will continue to be much more rapid because of this shortcut to knowledge of the purity of the preparation under study.

It is well known that microscopic estimation of purity is qualitative, but it serves to aid in choosing quickly between two differently prepared samples without the necessity of waiting for long animal experiments to materialize.

Another application of the electron microscope to medical problems may be seen in the recent work on collagen and muscle fibrils. These tiny filaments, too small to be studied with light, are under intensive study with the electron microscope and



Micrographs of B. megatherium taken with the light microscope (a), and with the electron microscope (b) and (c). Magnification (a) and (b) about 2230 x and (c) about 6000 x.

new information on muscle structure has already been reported.

The usefulness of the electron microscope is by no means limited to hitherto invisible objects. On the contrary, the new microscope offers many possibilities for further studies, for instance, of bacteria, on a scale of an entirely different order of magnitude from that previously attainable. This is illustrated by a comparison of the possibilities afforded by the two instruments. Electron pictures can be made at a magnification comparable with that obtained with the light microscope.

Electron Pictures Sharper

In the accompanying micrographs there is shown at (a) the appearance of B. megatherium in a light microscope photographed without oil immersion (871 x) and enlarged to match in size the small electron picture (b) of the identical individual organisms at a magnification of 2230 x. The electron picture is much sharper than the other, so sharp, in fact, that it can be enlarged several times (c) before diffuseness appears. In this enlargement many features of internal structure are revealed.

The electron microscope has been of little direct use thus far in clinical medicine. In the hospital the electron microscope stands apart from the clinic, seldom if ever seen by the average doctor. There are two reasons for this and the first is probably of much less importance than the second. The early instruments were large and expensive, of great complication and requiring the services of a physicist or radio engineer for proper maintenance and operation. As long as leaks develop in a high vacuum system and thermionic devices fail, such conditions will persist, but these things can be and are being minimized.

The second reason is more fundamental. The electron microscope is not aiding directly in diagnoses at the present time because few people have had time to learn how things look in the new instrument. It will require many years of careful study and classification before one will have at hand, for instance, as much detailed information on the appearance of viruses in the electron microscope as medical men now have at their disposal on the appearance of bacteria in the light microscope.

However, few diagnoses can be made on light microscopic findings alone. In the virus field there are more obstacles to direct diagnosis with the electron microscope than stand in the way of bacterial work with the light microscope. Bacteria can frequently be grown out in pure culture in a few days directly from the patient. Viruses do not grow on anything but living media and are such obligate parasites that isolation of them from a patient and cultivation even in chick embryos are exceedingly difficult.

There appears to exist a fairly widespread popular misconception that the doctor now has in his office an important new diagnostic tool. This may prove to be so, with the manufacture of smaller, less expensive electron microscopes and with the consequent rapidly increasing fund of information on the appearace of small infectious agents and other microstructures.

For the present, however, the field of contribution of this instrument is limited almost entirely to the research department of the hospital. Here, its possibilities are manifold for the study of all bodies and fine structures down to 100 times as small as the smallest object visible in the light microscope. Progress is limited only by the number, imagination and resourcefulness of the research workers.

Computing Patient Day Rates

NO GENERAL routine for computing patient day charges exists throughout the hospital field. Some hospitals bill but one day's charge if a patient remains less than forty-eight hours. Others compute the extra day on a fractional basis. In hotels, often an hour is set beyond which a pro rata charge is levied if the room is not vacated. For example, a guest entering a hotel room at noon on a given day must vacate by 4 p.m. or 6 p.m. on the succeeding day unless he expects to pay for the extra time.

Hospitals frequently set such an hour. The room rent is divided in three or four parts and if one meal is served beyond the twenty-four hour period a third or fourth of the rate card price for the particular accommodation is added to the patient's bill. This seems like a small matter but some definite bookkeeping policy should exist since in the course of a year's time the presence or absence of such a plan will result in a considerable profit or loss to the hospital. It is probably unfair to the patient to charge for a full day if but a fraction of an extra day is spent in the hospital.—J. C. DOANE, M.D., *medical director, Jewish Hospital, Philadelphia.*

They are on the conservative side

When it comes to Diagnostic Facilities

MOST of the small hospitals that reported on their aspirations regarding diagnostic facilities are conservative about major changes in present methods. The majority is against flat rates, group practice and doctors' offices in the hospital.

Only 11 hospitals replied to a questionnaire on this subject sent to 50 institutions; perhaps the subject matter seemed baffling to many of them.

All Provide X-Ray Service

Of these 11 hospitals, all provide x-ray service, 10 have laboratory service, nine give metabolic tests, five provide electrocardiographs. Three hospitals have a radiologist to provide their x-ray service, four rely on general practitioners, nine have technicians, one assigns this work to a nurse and one relies on an osteopath who has specialized in radiology. (Several, of course, have both technicians and physicians.)

For laboratory service one hospital has a pathologist, two use general practitioners, nine have technicians, one has a visiting consultant, one uses a commercial laboratory, one, a public health laboratory and one, a nurse. All of the hospitals reporting a metabolic determination service put this under the jurisdiction of a technician.

Electrocardiographic service is under the direction of a technician in three hospitals, under an osteopath in one and under the radiologist in the other.

From time to time, thoughtful patients have asked hospitals if they would not provide a comprehensive diagnostic service for a fixed total fee, such as $25 or $50. Such a service would include all necessary tests and the services of all the various doctors needed. In many instances, no doubt, it is the existence of such a service that influences patients to travel to such organizations as the Mayo Clinic.

The small hospitals were asked about this. Three of them are in favor and five opposed, with three unable or unwilling to express an opinion.

The "anti" opinions expressed were as follows:

"I do not thing this is advisable. The patients of a small community seem to have the idea that their doctor is *the* one and only." *Mercy Hospital, Anamosa, Iowa (35 beds).*

"Personally, I believe that it would be cheaper for the greater number of patients if the flat rate diagnostic service was not used. There would undoubtedly be a few who would benefit by a flat rate charge but I believe they would be a very small minority." J. ALBERT BOULTON, *Park City Miners Hospital, Park City, Utah (35 beds).*

"I thing it desirable but not feasible." SISTER STANISLAUS, R.N., *St. Mary's Hospital, Astoria, Ore. (100 beds).*

Patients Need Educating

"It may seem too expensive to the average patient admitted here, until he could be educated regarding the necessity for full laboratory tests." HELEN L. BROUGHTON, *Clay County Hospital, Brazil, Ind. (15 beds).*

"With only one doctor on our hospital staff, it would hardly be advisable." LOUISE WAHL, R.N., *Eureka Community Hospital, Eureka, S. D. (21 beds).*

The favorable opinions were:

"We maintain an in-patient diagnostic service operated by specialists with one doctor acting as coordinator. We charge a minimum fee of $35 which is split among the doctors for their services. The patient pays for day-rate service, x-rays and laboratory work separately." O. B. BIRDSALL, *Art Centre Hospital, Detroit (75 beds).*

"I think it would be most desirable from both the hospital's and the patients' standpoints. However, as the radiologist is not always on a stipulated salary, it would not be practical for all hospitals." MRS. JEWELL THRASHER, *Frasier-Ellis Hospital, Dothan, Ala. (66 beds).*

So far as the last point is concerned, it could probably be surmounted since, usually, internists, surgeons and other staff men are not on salary either.

Would you like to be able to obtain readily the services of specialists skilled in various types of diagnosis as consultants to your own staff?" was the next question.

Consultation Service Wanted

Seven hospitals report that they either have such specialists now available or would like to have them. Three failed to answer the question and one reports miraculously that it is hard to say "as we rarely have to send patients to skilled specialists and rarely do doctors find it difficult to diagnose their cases."

Group practice has often been suggested as a means of aiding the doctors on the staff of a small hospital to improve their work. Three of the hospital administrators think it would be valuable, five do not and three made no answer.

Mr. Boulton says: "I can see the possibility for considerable discord among the doctors in a small clinic. If it were possible to obtain the advice of a recognized specialist, there would be better feeling among the doctors of a small clinic."

"We do not see any advantage in this at all," writes SISTER M. GERALDINE, *St. Mary's Hospital, Camrose,*

Alta. (65 beds). "Work would not be divided evenly. Doctors in small places prefer looking after their own cases entirely."

MABEL L. PARSONS, *Elliot Community Hospital, Keene, N. H. (89 beds)* says that she has had no small hospital experience with this idea. "I believe it should be valuable to both doctor and patient, except that there is likely to be professional jealousy in the small community." This human failing is not limited to small communities, we might add.

Louise Wahl comes out flatly for group practice. "The doctors would be able to work together as a team and they would add greatly to their local community by keeping more cases here whereas they send them to clinics otherwise."

Mrs. Thrasher says that "the great advantage is that it enables more frequent consultations."

The Sister at Mercy Hospital, Anamosa, Iowa, says she is not in favor of this type of group "in a small hospital especially" while Mr. Birdsall says that it would be detrimental to the other physicians on the general staff.

"Near But Not In" Preferred

Asked whether doctors should have offices in or near the small hospital, one says yes and three say *near* but not *in* the hospital. Five correspondents oppose the idea.

Most hospitals in small communities are located as far as possible from the business district for the good of the patients, according to Mr. Boulton. "If the doctors had their offices in the hospital, it would be inconvenient for the people to call at the doctor's office, whereas if the doctor's office is in the business district he will be able to treat more people conveniently."

Miss Broughton objects that doctors' offices in the hospital would consume too much of the time of nurses or aides. Miss Wahl fears the small hospital is too disturbed a place and too crowded to have doctors' offices.

Of course, if doctors' offices were moved into present hospitals without any real provision for them in the way of adequate space or personnel, there would be confusion, crowding and overwork. If it is done, there should be adequate space, closely related to but shielded from the patient areas, and enough personnel should be available.

New Hospital Bed With All the Comforts of Home

A REVOLUTIONARY new type of hospital bed that may have important effects on future hospital planning and hospital nursing has been developed by Dr. Marvel Darlington Beem of Los Angeles. Although at first blush it might seem to resemble a Rube Goldberg cartoon, it has been sufficiently well developed so that one of the leading hospital supply houses will offer it for sale within the next six to twelve months.

The most important of many innovations in this bed is that it contains a full sized flush toilet and a lavatory with hot and cold running water and drains. These appear and disappear in 35 seconds merely on touching electric switches.

In addition the bed has: (1) mechanized lifts; (2) a disappearing overhead bar to aid patients in moving about in bed; (3) a top section that is removable for transporting the patient; (4) a built-in cabinet for supplies and linens; (5) built-in retractable orthopedic posts and side boards; (6) automatic push-button control of the spring and mattress to give various positions, including Trendelenburg and rigid frame; (7) self-contained reading lights; (8) automatically operated overbed table; (9) retractable step for getting in and out of bed; (10) emesis basin at head of bed with running water and drain, and (11) large dressing table that may also be used as an ordinary bedside table.

The toilet is a full-sized regular toilet so designed that the seat automatically takes any angle taken by the thigh section of the bed, level with the mattress whether the patient is flat, at an angle or sitting up. One section of the bed is automatically removed as the toilet comes into position; this section acts as an arm-rest and contains toilet paper and napkin box. The toilet also swings outside the bed for use when the patient is ambulatory.

The added width of the bed gives increased comfort and a sense of safety.

The lavatory may be brought to rest beside the patient's right thigh or stopped in its circle of travel for use by doctor or nurse. Switches control the room lights and window blinds.

The principal advantages claimed for the Beem bed are that it provides greater comfort for the patient and saves steps and work for the nurse and physician.

In a new hospital where the plumbing can be installed during construction, the elimination of toilets or utility rooms is said to make more space available for bedrooms.

The bed will probably sell for about $1000. There will, of course, be extra plumbing and electric connections.

My First Day on West III

MRS. JOSEPH CUSHING
Gray Lady
Springfield Hospital
Springfield, Mass.

I JUMPED off the bus and hurried up the walk to Springfield Hospital, Springfield, Mass., resolving to get an earlier bus next week.

"Good morning, are you Mrs. C.?" asked the secretary of volunteers. "Do you mind reporting to West III?"

My heart sank. West III—Chronic! Of course, I minded. I was downright scared. To my own amazement I heard myself saying: "Oh, no, I want to go where they need me most."

Somehow I found myself on the third floor and hesitated at the entrance to West III. Cautiously I advanced and near the first door a pleasant looking woman sat in a wheel chair. "Good morning, did you come to take me down?" she smiled. "Why, I don't know," I stammered. "I am just going to report to the head nurse." "Oh, I guess you are new," she replied. "The nurses' station is straight ahead at the right."

They Were Glad to See Me

I reached the nurses' station but no one was there and I stood looking down an endless corridor. Would I ever get to find my way around? In a few seconds a nurse dashed out of somewhere and rushed toward me. "Oh, Gray Lady, am I glad to see you! We have one this morning but could use a dozen. Follow me. There are some beds to be made."

With difficulty I kept up with her as she sped along and we finally turned into a ward for men. "There are five beds right here to be made, and when you finish these you can fill the bottles with mouth wash—I'll show you where to get it—and tidy up here a bit and then—"

A nice looking boy rolled along in a wheel chair and the nurse interrupted herself: "Oh, Frank, you haven't gone down yet. Mrs. D., will you take Frank down now and also get Louise and take her down, too, and when you get back I'll finish telling you what to do." As she dashed off I looked rather bewildered, I guess, for Frank smiled and said: "Guess you're new, aren't you? I'll show you where to go. You'll get on to it soon."

Aside from the whirl of things to be done, I was impressed with the quiet, cheerful atmosphere of the hospital. Somewhere across the hall a radio was playing; a fairly young-looking man in a wheel chair near by was discussing the presidential campaign with an older man who was busy repairing a radio. I was beginning to feel a bit easier. The patients in this unit were friendly, courteous and apparently contented. The nurse had been most considerate in starting me here.

In the next unit, the atmosphere was not quite so cheerful. With the exception of "Grandma" all were in bed and suffering more or less. "You are big and husky," one of them greeted me enviously. "I used to be like you once." "Well, perhaps you will again," I answered as consolingly as I could and set about making her like me. It took time and patience but I finally left her smiling, a pink bow in her hair and her finger nails brightly painted. The hair ribbons had been a gift of the Gray Ladies to everyone at Easter, she told me.

Returning from lunch, I found many persons rushing around with trays (including the Gray Lady I had not seen all morning) and I helped to pass them out. This took me into some units I had not seen and here the patients were more helpless.

As I passed one bed the woman was crying and shaking, a most unprepossessing sight, and I hurried along a bit frightened. When I returned to the dinner truck the nurse asked me to take Mrs. B.'s tray and feed her. When I found Mrs. B. was the crying woman I had tried to avoid, I didn't think I could possibly do it. However, in spite of myself I went on. It took only a few minutes to make her comfortable and her gratitude made me humble and ashamed. When we parted friends, I felt that I had won a victory over myself.

The next tray went to a little old lady who despite her Irish name looked like an Italian wood carving. "Just a little milk, nurse," she said. "I don't feel very good." So helpless and old and yet she did not seem too unlike a helpless baby.

The next hour was hectic, errands here and there, supplies to be got from the ground floor and sixth floor, glimpses of a new world. Nearly time to stop for the day and I am ready. "Oh, Mrs. C.," said the nurse catching sight of me, "two hampers of linen have just come up. Do you mind putting it away?" An hour and a half later I signed out feeling guilty even then for leaving.

But It Was Worth While

I was exhausted physically and emotionally but with a gratifying sense of having spent a worth-while day. Yet what had I done? Nothing spectacular. And if I had done any little good I surely had received more than I had given. What is "good"? The lines of John Boyle O'Reilly's rhyme came to mind. My mother used to recite it to us as children long, long ago.

"What is the real good?"
I asked in musing mood.

Order, said the law court;
Knowledge, said the school;
Truth, said the wise man;
Pleasure, said the fool;
Love, said the maiden;
Beauty, said the page;
Freedom, said the dreamer;
Home, said the sage;
Fame, said the soldier;
Equity, the seer;

Spoke my heart full sadly:
"The answer is not here."

Then within my bosom
Softly this I heard:
"Each heart holds the secret:
Kindness is the word."

—JOHN BOYLE O'REILLY.

This report was prepared by one of the Gray Ladies who have rendered invaluable assistance in caring for the chronic disease patients. See "Report on a Decade of Experience," by Eugene Walker, M.D., and Jennie F. I. Dixon, June MODERN HOSPITAL, page 55.

To Serve the Navy on Land

Administration building of the 200 bed hospital at Charleston Navy Yard. In addition to this building the hospital consists of a subsistence unit and ward buildings, all of them connected by enclosed corridors.

JAMES R. BRANSON
Division of Information
Federal Works Agency
Washington, D. C.

SPONSORED by the Navy Department, a modern fireproof hospital has been constructed at the Navy yard in Charleston, S. C., by the Work Projects Administration at a cost of $1,063,562, and is now in use in an area where the need had become vital for such an institution.

Designed as a 200 bed hospital, construction is such that facilities could be expanded to accommodate 380 patients. It replaces an old 57 bed hospital housed in temporary frame buildings which had been damaged badly by termites.

When it became increasingly evident that hospitalization needs had outgrown existing and outmoded facilities, plans were made for the construction of an adequate modern plant to serve the needs of naval establishments in the Southeast, as well as the Navy Yard itself. Efforts were made to obtain a Navy Department appropriation for the work but this was unsuccessful. R/A W. H. Allen, commandant of the Navy Yard and the Sixth Naval District, appealed to the Work Projects Administration for aid, which was subsequently granted.

Built of reenforced concrete, the hospital consists of two main buildings—an administration building and a subsistence building—each flanked by ward buildings, all connected by enclosed corridors. These provide administrative offices and operating, laboratory, laundry and mess facilities for existing ward buildings.

Realizing that the construction of a modern hospital is a job of considerable complexity, every effort was made to adjust the type of construction to provide simple, economical and rapid fabrication. This was evidenced first by the location of the plant on one of the highest knolls in the reservation, one of the few sites that would not require pile foundations for structures of the size contemplated.

A concrete structural frame was designed which incorporated the use of precast concrete joists; this simplified the form work required. Cinder concrete block exterior walls were chosen as the finish in the interest of economy and the utilization of the maximum of W.P.A. unskilled laborers in their production and laying.

Cinders were available from the Yard's power plant and permission was obtained from the central office for the making of the blocks. No objections were registered by private industry engaged in making such blocks commercially; on the contrary the local block manufacturer taught the workers the process and helped put operations on a production basis. To the sponsor, the blocks produced in this plant represent a net saving of 10 cents each.

The hospital comprises a group of buildings laid out around a central court, all of the buildings being connected by an enclosed corridor. These buildings consist of a two-story and basement administration building, 197 by 52 feet, which houses the administrative offices; the laboratories and the surgical department; a one story and basement subsistence building, 178 by 101 feet, which houses the mess facilities and the hospital's power plant; four one story and basement ward buildings, 240 by 33 feet, designed as surgical, urological and dermatological, eye, ear, nose and throat and family clinic, and four single story ward buildings, 240 by 33 feet, designated as sick officers' quarters and medical psychopathic and isolation departments.

About People

Administrators

Robert D. Southwick, formerly of Portage County Hospital, Ravenna, Ohio, will take over the deputy superintendency at Gallinger Municipal Hospital, Washington, D. C., vacated by **John F. Barker.** Mr. Southwick in going to the 1640 bed Gallinger is not a stranger to large hospitals as he was connected with University Hospitals, Cleveland, for nine years.

Royal E. Raper, formerly at Memorial Hospital of Springfield, Springfield, Ill., is the new superintendent of Saginaw General Hospital, Saginaw, Mich., succeeding **Mrs. Kate J. Hard,** who has retired. Mr. Raper took up his new duties on September 1.

Amy J. Daniels resigned her position as superintendent of Elkhart General Hospital, Elkhart, Ind., on July 21.

J. Vincent Gallagher became assistant administrator of Lawrence and Memorial Associated Hospitals, New London, Conn., on August 1. A graduate of Alexian Brothers Hospital, Chicago, Mr. Gallagher did postgraduate work in various departments in that hospital and has had special training in accountancy at Columbus University, Washington, D. C. Before taking the New London post, he had supervision of hospital, clinics, infirmaries and the tuberculosis pavilion at the District of Columbia Reformatory. **Richard J. Hancock** is the administrator at Lawrence and Memorial.

Dr. Louis J. Bristow, superintendent of Southern Baptist Hospital, New Orleans, has been appointed general secretary of the Southern Baptist Hospitals' Board and will devote his time to the development of new Baptist hospitals in the South. **Frank S. Groner,** former assistant superintendent at the New Orleans institution, has been promoted to the position of administrator.

Mayme A. Peck, R.N., on September 1 assumed the superintendency of Hershfield Cardiac Home, Hillburn, Rockland County, New York. This is a new institution being operated for rehabilitation of certain types of cardiac disease. It is nonsectarian and all patients will be admitted without charge. The first patients will be received by October 15, according to plans.

E. F. Saunders, former superintendent of the hospital at Corry, Pa., is the new administrator of Potter County Memorial Hospital, Coudersport, Pa., a 60 bed institution.

Sister Ligouri has succeeded **Sister Alfreda** as administrator of Mercy Hospital, Manistee, Mich. Sister Alfreda has been transferred to Hammond, Ind.

Adelaide H. Guthrie has resigned as superintendent of the Hospital and Home for Crippled Children, Newark, N. J. **Mrs. Alixe E. Villochi** has been appointed acting superintendent.

Dr. Curtis H. Lohr, after two years overseas duty with the Army, has resumed the superintendency of St. Louis County Hospital, Clayton, Mo.

George W. Unruh Jr. has become administrator of Riverside Hospital, Paducah, Ky., succeeding **S. J. Ruskjer.** Mr. Unruh was business manager of Vicksburg Hospital, Inc. and Vicksburg Clinic in Vicksburg, Miss., for five years. Before entering the hospital field, he was a public accountant in New Orleans.

Amy Beers, R. N., for twenty-one years superintendent of Hackley Hospital, Muskegon, Mich., has submitted her resignation, to take effect October 1. Miss Beers is a fellow of the American College of Hospital Administrators and served as second vice president in 1942. She has also acted in the capacities of treasurer, president and trustee of the Michigan Hospital Association and has been active in the affairs of the nursing organizations.

Department Heads

Mrs. Doris L. Dungan has resigned as executive housekeeper of Hartford Hospital, Hartford, Conn., to become executive housekeeper of Western Pennsylvania Hospital, Pittsburgh. Mrs. Dungan was national president of the National Executive Housekeepers' Association from 1938 to 1942 and has taken an active part in the affairs of the association for some years.

Edith D. Payne is the new superintendent of nurses at Methodist Hospital, Philadelphia, having returned from the assistant superintendency of Presbyterian Hospital, Philadelphia, to head the school that graduated her. She succeeds **Agnes Taylor, R.N.,** now in Milwaukee.

Dr. Paul H. Harmon has been appointed chief surgeon and medical director of Morris Memorial Hospital for Crippled Children, Milton, W. Va.

Katharine Faville, R.N., has been named dean of the college of nursing at Wayne University, Detroit. Miss Faville went to Wayne as chairman of the department of nursing in March 1944 and was made acting dean when the college of nursing was created in October 1944. Miss Faville has been chairman of the committee on guidance of the National Nursing Council for War Service.

Lt. (j.g.) M. S. Vetting is the director of a staff of 15 that directs activities in the 14 workshops of the new occupational therapy building at the National Naval Medical Center, Bethesda, Md. The shops have a daily capacity of 300 patients. **Lt. Cmdr. H. S. Etter,** the rehabilitation officer of the Naval Hospital, has general supervision.

J. Marie Melgaard has resigned as director of the dietary department, University of Oklahoma Hospitals, Oklahoma City, to become administrative dietitian at St. Luke's Hospital, Denver.

Arthur A. Winston, who was formerly associated with Protestant Deaconess Hospital, Evansville, Ind., has assumed the position of purchasing agent at Shadyside Hospital, Pittsburgh.

Miscellaneous

Dr. Herbert T. Wagner has left Meriden Hospital, Meriden, Conn., and has been commissioned in the U. S. Public Health Service (R) with the rank of surgeon. He has been assigned to the hospital facilities section of the States Relations Division which is headed by Dr. Vane Hoge.

Basil Yurchenco, the architect who won second prize in The Modern Hospital's recent competition for small hospital designs, has been named an associate architect in Marshall Shaffer's office in the hospital facilities section of the States Relations Division, U.S.P.H.S. In collaboration with **E. F. Cahalane**

(*Continued on page* 166)

HEADLINE NEWS

Proposed $5,000,000,000 Public Works Backlog to Benefit Hospitals

By EVA ADAMS CROSS

WASHINGTON, D. C.—A recent report of the House special committee on postwar economic policy and planning recommends that the federal government make a fund available for distribution to states and local governments sufficient to build up a backlog of $5,000,000,000 of construction projects. This sum would be in addition to those which the state and local agencies have already undertaken on their own initiative. Hospitals are specifically included among institutions that would benefit.

During the war, the report points out, the construction of schools, hospitals and other institutions was in large part deferred. These constitute a large reservoir of public works, some urgently necessary and some deferrable. In the postwar pattern there appears to be room for an average yearly expenditure of about $800,000,000 during the immediate postwar years.

The committee stresses local responsibility in the construction of public health, hospitalization and local welfare units. Nevertheless, for certain longer-term projects, the federal government should be prepared, according to the report, to speed up construction by advancing loans if needed.

Federal aid is justified, according to the report, when there is a let-down in business activity, particularly in construction, and when communities might find it desirable to accelerate these long-term projects, for the sake of relieving unemployment.

The federal government, says the report, should encourage state and local governments to prepare a reserve shelf of useful, deferrable public works against future unemployment.

First Medical Officer Released

WASHINGTON, D. C.—The first medical officer to receive a discharge under the Army's point system was Maj. Wallace P. Ritchie of St. Paul, Minn. He had amassed a total of 121 points. Major Ritchie received papers from the Surgeon General's Office within a few hours after he landed at Bolling Field directing him to proceed to the separation center at Fort Sheridan, Ill. He had served overseas for 32 months and wore three battle stars in his campaign ribbon.

Officials List Controls Eased by End of War in Pacific

By EVA ADAMS CROSS

WASHINGTON, D. C.—The end of the war saw quick action by nearly every federal agency to speed the conversion to peace. Production and manpower controls were removed, wage and salary ceilings were opened up, travel restrictions were eased, rationing was eliminated for most foods and further efforts were made to dispose of surplus property. Although the war ended suddenly, most federal agencies seemed quite well prepared to cope with the changed situation promptly.

The *Office of Defense Transportation* has issued an order slightly relaxing convention controls by increasing the number who might assemble in one center from out-of-town from 50 to 150 persons. Gen. Brehon B. Somervell, Chief of Army Service Forces, says, however, that civilian railroad travel will continue to be tight for at least a year.

John W. Snyder, *Office of War Mobilization and Reconversion,* said in a report to the President that all controls over manpower are to be removed and the compulsory forty-eight-hour week ended at once. The removal of such controls does not affect the nursing program at this time.

All *War Production Board* controls except for a few to avoid dislocation of expanding peace-time economy, to prevent the hoarding of materials and to prevent bottlenecks will be removed at once, according to J. A. Krug, W.P.B. chairman. Bottlenecks that may hinder production will be broken and help will be given to ensure the manufacture of essential military or civilian goods, Mr. Krug declared. For as long as they are needed, controls will be continued over scarce materials, such as tin, crude rubber, textiles and lumber. More than 200 W.P.B. orders and regulations outstanding at V-E Day have been revoked.

The *Office of Price Administration* has removed canned goods from rationing controls but Chester Bowles, O.P.A. chief, warned that shortages are still acute along many lines. Guarding of prices of food and clothing must be continued, he said. Inflationary pressures will push hardest against goods long off the market. Refrigerators, automobiles, radios and washing machines must come back into the stores at about the same prices they had when they went out of production in 1942 and cost of building materials must be held down, he continued.

The *Surplus Property Board* in a statement issued on V-J Day said that, "We face the task of using the vast amount of war surplus to create peace-time jobs, to speed peace-time production, to meet shortages, to help veterans, to benefit public health, education and transportation and to get a fair return for the people." State and local governments are receiving the priority to which the law entitles them, and provisions are being made to give them medical and educational surpluses at nominal costs on a basis of need.

Confusion Confounded in Textile Situation

WASHINGTON, D. C.—Further confusion in the textile situation as it affects hospitals was added by the amendment of Order M-317A, adopted on August 11. This added various fabrics to the schedule and required hospitals to file applications for priority assistance within fifteen days after the date the fabrics were added.

The whole system of priority assistance for fabrics threatened to fall of its own weight because of the unworkable program set up by W.P.B. On July 30 W.P.B. complained that the processing of applications for preference ratings to obtain cotton fabrics is delayed because the application forms, in many cases, have not been filled out correctly. However, W.P.B. has not issued instructions to the hospitals concerning the filling out of these reports.

Hospital Units in Reserve

WASHINGTON, D. C.—Affiliated hospital units now serving in the Army of the United States will not be disbanded after the war but will continue on an inactive reserve status as part of the postwar military establishment, the War Department announced on August 13.

Catholic Convention Canceled

The 1945 convention of the Catholic Hospital Association has been canceled, it was announced August 1.

Lanham Act Grants Rescinded Unless Construction Has Started

WASHINGTON, D. C.—Federal grants under the Lanham Act to nonfederal projects will be actually paid only if contracts have been awarded and if on review it can be shown that the projects are still justified, the Federal Works Agency announced on August 19.

All federal projects not actually under construction, even though contracts have been awarded, are to be suspended; federal projects under construction may be continued to full completion or to completion of a useful unit if it can be conclusively shown that the need for the facility will exist in the postwar period and the sponsoring federal agency requests completion.

Nonfederal war public works construction projects on which contracts have been awarded, whether construction has started or not, and where the federal grant equals or exceeds 75 per cent of the cost, are to be reexamined in the same manner as federal projects. The division engineer is to make a report and recommendation on each project.

Hospitals Under This Order

Most hospital projects would come under the section of the new order to division engineers reading as follows: "Nonfederal construction projects on which contracts have already been let or on which actual construction has been started may be continued to completion if a written request for such continuation is submitted to the division engineer by the applicant stating that the project will serve a useful purpose in the postwar period when completed and agreeing to provide any additional funds which may be required to complete the project, as well as all funds required for its maintenance and operation. Forward report and recommendation on each such project.

"On nonfederal construction projects for which allotments have been made but on which no contracts have yet been approved for construction, the division engineer shall take prompt steps to notify the applicant and negotiate the recession of allotments. All such projects were approved on the understanding that the project was to meet a war need and now that the war is over we are not able to certify that the project has a war need."

Assistance for the operation of general hospitals will be approved until October 31 in areas where the war impact requires continuation of these services until that time. Continuation beyond that date will be decided by October 10.

On August 14, W.P.B. announced the termination of its "Community Facilities Program" which coordinated the activities of various governmental agencies in ensuring construction of civilian facilities in war areas. These included, among others, hospitals, schools and sanitary facilities. "The work will be carried on by appropriate governmental and civic organizations under standard criteria and procedures that have been developed as a result of the W.P.B. program," declared William Y. Elliott, W.P.B. former vice chairman for civilian requirements.

Construction costs will be kept down through a building cost control program, announced by O.P.A. on August 15. "Our forthcoming program of dollar-and-cent prices on many building materials and services will . . . help to provide schools, hospitals and health centers at reasonable costs," declared Chester Bowles, O.P.A. administrator.

A.H.A. Asks Extension of Cadet Nurse Corps

WASHINGTON, D. C.—President Truman has been officially and vigorously requested by the American Hospital Association to delay declaring an end to the emergency until January 15 so that students in the cadet nurse corps who enter in September and October classes can be carried through to the completion of their courses. According to the Bolton Bill, any student who has served ninety days in the cadet nurse corps before the emergency is ended can be carried with full federal aid.

The emergency can be terminated by the President by a general declaration, by a specific declaration affecting only the corps or by a joint resolution of Congress.

Hospitals throughout the country are reported to be still short of nurses and will be hard hit if they lose the benefits of the corps.

The request of the A.H.A. was supported by Sen. Elbert D. Thomas, who pointed out in a letter to the President that designating Jan. 15, 1946, as the terminal date of the act would be fair to the students, their families and the government. Setting any earlier date, the senator declared, would be bad faith on the part of the government in its dealings with both the cadets and the hospitals.

W.P.B. Abolishes 210 Control Orders

WASHINGTON, D. C.—A total of 210 W.P.B. control orders was abolished at one stroke on August 20 and several others earlier. Those of interest to hospitals were:

Order M-300, *Schedule 25-Schedule 44*—Synthetic organic detergents; *Schedule 78*—Carbon Tetrachloride; *Schedule 93*—High test calcium hypochlorite.

L-5-c—Domestic mechanical refrigerators.

L-6—Domestic laundry equipment.

L-13-b—Use of metal in furniture and fixtures.

L-71—Dry cell batteries and portable electric lights.

L-79—Plumbing, heating and cooking equipment.

L-176—Domestic and commercial electric fans.

L-178—Film.

L-233—Photographic film and film base.

L-233-a—Delivery of sensitized photographic paper.

L-336—Paper cups and paper containers.

M-9—Copper.

L-350—Softwood veneer.

L-23-c—Domestic cooking appliances and domestic heating stoves.

L-42—Plumbing and heating simplification; *Schedule 4*, cast iron soil pipe and fittings.

L-248—Commercial dish washers.

L-349—Oil-burning equipment.

L-265—Electronic equipment.

L-272—Industrial instruments; *Schedule 1*, control valves.

L-139—Dental equipment and supplies simplification; *Schedule 1*—dental excavating burrs.

L-144—Laboratory equipment.

L-295—Dental burrs.

L-95—Sanitary napkins.

M-73—Wool.

M-91—Cotton duck.

M-102—Water fowl feathers.

W.P.B. also announced on August 20 that student nurses' uniforms may now be sold to distributors if they certify that the uniforms are going to be resold for the ultimate use of student nurses.

Wounded Home From War

WASHINGTON, D. C.—Before V-J Day the Army announced the plan to have all transportable sick and wounded soldiers home from Europe by July 27. Most of them were home within sixty days of May 8, V-E Day. Following World War I, it took nearly a year to get the sick and wounded soldiers home.

U.S.P.H.S. May Be Given Authority to Dispose of Surplus Medical Supplies

WASHINGTON, D. C.—While the details have not been officially worked out or given public release, it now appears almost certain that the U. S. Public Health Service will have a large responsibility for the disposal of medical and hospital supplies that become available as war surplus. As of August 20, final approval of the tentative program had not been announced by the Surplus Property Board.

The program had moved forward far enough, however, so that Surgeon General Parran had designated Dr. Joseph O. Dean as the Public Health Service officer to be in charge of this work and Lt. Col. Neil F. MacDonald had been chosen as one of his assistants.

The U.S.P.H.S. will be able to assist in disposing of property in such a way as to obtain the best results in terms of national health and, especially, the channeling of such materials to under-equipped communities. It is expected that planning and advisory groups will be formed at the state and federal levels to represent the public and the professions. At the state level, these groups can stimulate and assist eligible hospitals or communities to ascertain their needs and make application for them.

In addition, the U.S.P.H.S. can, through its existing services, advise communities or groups regarding construction and operating costs, appropriateness of plans and significance of need. Disposal will be to states, local governments and nonprofit institutions for all types of public health and medical purposes.

The Surplus Property Board announced on V-J day that "provisions are being made to give state and local governments the property to which the law entitles them and to give them medical and educational surpluses at nominal costs on a basis of need."

The over-all objective of the U. S. Public Health Service is to assist the Surplus Property Board and disposal agencies in disposing of property for purposes of health protection in a manner which best serves the national interest and to obtain for purposes of health protection the widest utilization of surplus materials in under-equipped communities.

It is expected that the U. S. P. H. S. will work closely with the U. S. Office of Education on matters of common interest and will exchange information and develop jointly plans and estimates of need, particularly for agencies eligible both in the health and educational fields.

Doctor Dean is a seasoned officer of the Public Health Service, having served since 1928. For the past year he has been assistant chief of the division of states relations under Dr. Joseph Mountin. Prior to that Doctor Dean was medical consultant in the district office in San Juan, Puerto Rico. This office had charge of a Marine hospital and quarantine station and general public health administration. He has written several articles for *Public Health Reports* on health surveys in Virginia.

Colonel MacDonald is a graduate of the hospital administration course of the University of Chicago and took his administrative internship under Dr. B. W. Black of Alameda, Calif. Since then he has done hospital consultation and survey work with Griffenhagen and Associates and with the Office of William Henry Walsh. He has been a senior hospital consultant with the U.S.P.H.S. since 1941 and in 1944 was assigned to U.N.R.R.A. and detailed to the North-Africa-European Theater. Because of an eye operation he was in a U. S. Naval Hospital from January 24 to May 15 of this year.

McNutt Proposes Enrollment of 12,000 Medical and Dental Students

WASHINGTON, D. C.—To meet the serious shortage of doctors and dentists, Paul V. McNutt, chairman of the War Manpower Commission, on August 20 announced plans to enroll 12,000 students immediately for medical, dental, premedical and predental courses this fall from among veterans being discharged from the armed services. It is hoped to obtain 8000 for medical and premedical training, and 4000 for the dental groups.

Information concerning present opportunities in the medical and dental professions will be included in various publications reaching soldiers, sailors and marines in various parts of the world, with an explanation of the financial assistance available under the G.I. Bill of Rights. In addition, more comprehensive information will be furnished to counselors and education officers in assembly areas.

At all separation centers the most likely candidates for such training will be screened on the basis of their qualifications and expressed interest.

Educational information will also be supplied to prospects through veterans' employment representatives in local offices of the U.S.E.S., Veterans Administration and local Selective Service Boards.

Present estimates are that a peace-time Army will require 10,000 physicians, a peace-time Navy, about 5000 and the Veterans Administration, about 15,000. Furthermore, American trained doctors will be needed to rebuild the war-destroyed hospitals and medical schools of Europe and China.

There have also been casualties among American physicians in the armed forces and among overworked civilian doctors. The total present conservative estimate, according to Mr. McNutt, is for 35,000 additional doctors.

In dentistry the situation is even worse because the prewar supply was decreasing. From 1910 to 1940 the number of graduates in dentistry decreased 23 per cent while the population of the U. S. increased by 42 per cent. There was a prewar shortage and now the care given civilians by private dentists is principally emergency work. "There has been untold neglect of the oral health of all the people, especially children," Mr. McNutt said.

Hospitals Protected Under W.P.B. Plan

WASHINGTON, D. C.—The war-time priority system was practically abolished by W.P.B. on August 23 to be effective September 30. But certain protections were preserved, including one which apparently will safeguard hospitals.

All ratings were abolished except AAA, the new military MM and a new CC rating and the AA ratings which apply to textiles. The controlled materials plan was abolished and allotments of steel, copper and aluminum were canceled.

The new CC rating may be assigned where needed to increase production, to eliminate bottlenecks and to protect public health and welfare.

Plan Public Welfare Department

WASHINGTON, D. C.—Plans to be submitted to Congress after it reconvenes September 5 involve the setting up of a new department of government, a Department of Public Welfare. The new department would include the Federal Security Agency, the Public Health Service, the Children's Bureau and probably other bureaus. It would be headed by a cabinet officer, the first to be added for 32 years.

Medical Research Emphasized in New National Science Foundation Bill

By EVA ADAMS CROSS

WASHINGTON, D. C.—Another carefully drafted bill in which the Senate Subcommittee on War-Time Health and Education had a share is the Kilgore-Johnson-Pepper Bill of July 23 to establish a National Science Foundation. Emphasis was placed in its introduction on the medical research aspects of the proposed legislation.

Senator Pepper called particular attention to Title III which provides for the "Survey of Federal Scientific Activity and Use and Dissemination of Research Findings." The purpose of this title is to assure wide and prompt availability of scientific discoveries and developments in the best interests of the nation and the advancement of its security, health and welfare.

In the field of medical research a committee of nine outstanding men will have the responsibility for carrying on into the peace-time years the functions and the splendid record of the Committee on Medical Research of O.S.R.D.

The committee will have at its disposal, the Senator pointed out, 20 per cent of the funds to be appropriated to the National Science Foundation—funds available for scholarships, fellowships and contractual research projects.

Specifically the bill will:

1. Provide for an increase above prewar levels in the government's support of research and development in fields that are predominantly in the public interest, particularly national defense, health and medical science.

2. Provide for an efficient coordination of government-supported research activities.

3. Stimulate a general expansion in research by private organizations and institutions.

4. Promote a wider flow of scientific and technical information which may be useful to industry, agriculture and business, particularly small enterprises.

5. Encourage a rapid introduction and full use of scientific discoveries and the most advanced technics and inventions.

6. Encourage the training of new scientific talent through a system of research scholarships and fellowships.

Recently, several other bills of a similar nature have come before the Senate. H.R. 3440, now before the Senate Military Affairs Committee, would authorize appropriations for national defense to be made direct to the National Academy of Sciences; S. 825, pending in the Naval Affairs Committee, would establish instead a Research Committee for National Defense as the responsible operating unit; S. 1285, the Magnuson Bill which followed immediately on the report of Dr. Vannevar Bush to the President, takes a broader approach and covers considerably more than national defense research alone.

The Kilgore-Johnson-Pepper bill will be referred to the Military Affairs Committee if the request of its authors is heeded. It is hoped that arrangements can be made for joint hearings on these various bills so that the issues presented can be clarified and agreement can be reached at an early date.

A.H.A. Delegates to Meet; Convention Is Possible

The A.H.A. will definitely have a meeting this fall. If restrictions are still in effect, there will be a house of delegates session at the Drake Hotel, Chicago, on November 5, 6 and 7. If a complete convention can be held, it will probably be moved to Philadelphia and may be on a different date.

The Hospital Service Plan Commission will also hold a meeting of Blue Cross plans this fall. If the A.H.A. holds a complete convention, the plans will meet at the same time and place. If only a house of delegates meeting is held, the plans will probably meet in New York City on an earlier date.

Meanwhile in Washington, the O.D.T. on August 17 eliminated the 35 mile per hour speed limit, permitted traveling for major sporting events, permitted state and regional fairs, raised the convention limit from 50 out-of-town persons to 150, relaxed restrictions on group travel for business purposes but went on to predict that "war-created travel probably will be heavy until well into 1946." Early in 1946 several hundred new passenger coaches will be available and most of the federal order for 1200 troop sleepers and 400 kitchen cars is expected to be off production lines by the end of 1945.

A.D.A. Meeting Postponed

The twenty-eighth annual meeting of the American Dietetic Association, which was scheduled to be held at the Netherland Plaza Hotel, Cincinnati, October 15 to 19, has been postponed until October 1946.

Out-Patient Treatment for Veterans Approved by V. A. Administrator

By EVA ADAMS CROSS

WASHINGTON, D. C.—Out-patient treatment of veterans with service-connected disabilities in 31 mental hygiene clinics, and intensive treatment courses in 19 neurosis centers connected with general medical and surgical hospitals, have been authorized by the Administrator of Veterans Affairs, it was announced recently. The clinics will make treatment readily available to veterans disabled in service who are in need of reorientation. Return to normal life and a gainful occupation will be expedited.

Each of the clinics and neurosis centers will be staffed by a chief psychiatrist and assistant psychiatrists, psychologists and psychiatric social workers. The staffs will be trained in the newest dynamic methods of treatment. Each out-patient clinic will be fully equipped for diagnosis and treatment with facilities on hand for x-ray and clinical laboratory examination. The neurosis centers will be equipped for intensive therapy of the severe neuropsychiatric patient.

In addition to the full-time staff, outstanding psychiatrists in each locality are being sought on a fee basis to devote part of their time to the mental hygiene clinics and to serve as consultants. While staffs of all veterans hospitals are depleted as a result of war conditions, it is believed that establishment of the out-patient clinics will materially reduce the load on existing neuropsychiatric hospitals.

Change Reference for Bill

WASHINGTON, D. C.—Senate Bill 1160 to establish a National Neuropsychiatric Institute has been referred to the Senate Committee on Education and Labor, a change in reference from the Committee on Commerce, at the request of Senator Pepper August 1. Sen. Josiah W. Bailey, chairman of the Commerce Committee, had asked Senator Pepper to make the motion that the Commerce Committee be discharged from consideration of the bill.

1008 Awards to Army Nurses

WASHINGTON, D. C.—Army nurses have received a total of 1008 decorations and awards since Dec. 7, 1941, the War Department announced July 31. Bronze Stars and Air Medals predominated. Sixty nurses have been awarded the Purple Heart, several posthumously. The Legion of Merit has been awarded to 12, the Soldier's' Medal to five and the Distinguished Service Medal to one.

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EDWARD K. WARREN
President
Greenwich Hospital
Greenwich, Conn.

WHO of us has not wondered at times why we do not receive more help from our individual board members in the formation of the policies of our organization? There may well be two very good reasons. We may not have stopped to consider just what it is that we have a right to expect of a board member or what the board member has a right to expect from the board.

First, the board has a right to expect of a member a complete acceptance of the chartered purpose of the organization. This is quite different from saying that a board member is expected to agree with all of the policies of the organization. As I shall attempt to show later, disagreement on policies is often a sign of health, but disagreement on the fundamental chartered purpose can only be damaging to the progress and efficiency of the organization.

Defend Special Interests

This first point may seem almost too elementary, but it is included for a definite reason. Many a board has members on it who are elected as representatives of different groups or parts of the community. Too frequently, they confuse their duty of bringing to the board the experience of their group or part of the community with an imagined duty of defending what they believe to be the special interests of their group or part of the community against all comers, including especially the board.

Second, the board has a right to expect faithfulness in attendance at its meetings and those of its committees. The problems facing us today are far too complex and too urgent to permit of any lesser contribution from a board member than the best he can possibly give in advice and counsel when he is actually present at the meetings. It is no longer enough for anyone to lend to the board the prestige of his name, no matter how honored that may be. It follows, of course, that, conversely, no member should accept election expecting to borrow from the board prestige or a preferred position for getting business.

Third, the board has a right to expect from its members a positive contribution in the formation of policy. Policy is at once the challenge and the responsibility of the board. Most of our larger organizations are operated with complete competence on a day-to-day basis by the professional staff within the framework of policies adopted by the board.

The strength of voluntary institutions lies in their flexibility. They are free to do anything not specifically prohibited by law. But of what use is this freedom unless they are ready to avail themselves of it, quickly adapting to changes in the character of the need?

This continuous adaptation is not spontaneous. It comes from an alertness on the part of the board members themselves to changing needs. It comes from a continuous questioning, "Is there still a need for my institution?" "Does my institution meet that need?" "Can its policies be changed so that it will better meet the need?"

These questions, and the board must ever be answering them, cannot be met from a knowledge of the operation of the institution gathered only from attendance at meetings and the reading of literature. The board member, to be useful in his particular point of vantage, must have a far more intimate and personal knowledge of his organization and must gain that at the cost of definite effort on his part.

One other reason why the alert and advised board member is a most important asset is that when groups of persons meet together there is always a tendency to accept the proposals put forth by the most persuasive advocate and it is only a sound knowledge of facts that enables an individual to weigh and balance the proposals on the basis of their merit rather than on the eloquence with which they were pleaded.

The second question that I asked, "What has a board member a right to expect of the board?" is just as important, for he has the right to expect that this group to which he has been elected will fulfill certain minimum demands in order to justify the effort on his part that the board will require of him. First, he has the right to expect that the board will be small enough to be able to become homogeneous and arrive at agreement on most of the matters that come before it.

Dominating Clique Dangerous

Second, he has a right to expect that it will be open-minded, free from the domination of any individual or group. This freedom from domination by a group is often aided by the rotation of membership. If the membership does not change frequently, it often follows that certain individuals on the board, genuinely interested in the work that is being done, find their points of view so congenial that they become an unconscious group, which, over the years, crystallizes into a dominating clique. This is extremely dangerous to good board relations.

Third, the trustee has a right to expect that while the board values the judgment and experience of those of its members who are profes-

sional men, such as lawyers or architects, it will not try to buy extensive and costly professional services from them at the low price of a board membership. It is excellent to have an architect on the board, but if a new building program is to be entered into it is important that a firm of architects be retained; in the interpretation of its plans the member of the board will tremendously serve the institution.

How can we best move to obtain such boards, composed of such board members? There are a few constructive efforts that we can make, but we must realize from the outset that these efforts will not be 100 per cent successful. Every board is bound to contain some members elected in response to this or that pressure, members who with all the good will in the world may turn out to belong to the class of persons I have heard characterized as "born to make a quorum."

In seeking new board members, we shall do better if we consider the qualifications set forth as being of paramount importance. If we do, and if we endeavor to provide the good board member, when elected, with a board worthy of his best efforts and eager to make the fullest possible use of his abilities, we may find ourselves less perplexed by that haunting question, "Why are board members bored?"

VOLUNTEER ACTIVITIES

Interested in Asthma

An unusual branch of women's volunteer activities is the Asthmatic Children's Aid of Mount Sinai Hospital, Chicago. It raises funds to support research in asthma and its initial contribution to Mount Sinai for this purpose was $2500. Besides research, it supports the hospital treatment and care of underprivileged children afflicted with this condition.

New Jobs for Volunteers

It is inspiring for volunteer workers to know what goals lie ahead for them. Here are the needs of just one service at one hospital as viewed by Dr. Helen Johnson, medical director of the Rheumatic Fever Clinic of the Children's Hospital of the East Bay, Oakland, Calif.

1. Establish a play center devoted to special occupational therapy for children who are well enough to be out of bed a few hours each day. Children could be brought in from their homes to the play center, as well as from the wards.
2. Set up a lending library of toys.
3. Form a group of "visiting toy ladies" who would go out to the homes where a harassed mother needs a hand in entertaining her convalescent child.

At present in this Rheumatic Fever Clinic volunteers act the part of receptionist; they take temperatures, weigh and measure child patients at each clinic and prepare them for the doctor's examination; they sterilize instruments and keep the receiving rooms in order.

Their work is not going to slacken when the war is won. They'll be busier than ever, it seems likely.

MV's Repair and Replace

The MV's at New Haven Hospital are a busy crew of around 130 men who put in a total of 1200 hours or more monthly. These men volunteers are supplemented by more than a score of Yale Aides.

The newest group of MV's is the repair and replacement division with 18 members. These men have built a massage table for physical therapy, storage shelving for the x-ray department and have made and put up 100 direction signs in the corridors to guide visitors about the institution.

No Food Shortage Here

The Commissariat is one of the active committees of the Woman's Aid Society of Paterson General Hospital, Paterson, N. J. How active, the chairman's colleagues did not realize until the official count of last year's food collections was made: 11,038 cans of fruits and vegetables, 291 packages of dry goods, 50 miscellaneous articles, 15 bushels of potatoes, apples and 59 glasses of jelly, making a total of 11,453 items. That is the record that this year's group hopes to equal.

The five other committees at Paterson General keep busy, too. The training school committee cuts out and makes all the nurses' caps and gives them to the student nurses; it makes curtains and dresser scarves for the nurses' home. The ladies of the private rooms' committee and the children's war committee sew industriously and finance redecorating projects.

But wait until you hear what the linen committee did last year: It collected *156 sheets* and 2700 other items and $653 in cash on Linen Day.

Question of the Month

Each month in this column one question bearing upon hospital trusteeship is presented and answered. The editor is glad to receive questions which any hospital trustee may submit. All identification will be withheld. Replies will be made by mail pending their publication.

QUESTION: Certain problems involving the signing of checks have come up in our hospital. I should like to know (1) what limits, if any, other hospitals are imposing for an individual and how many signatures with the title of employe and officer; also (2) what practice is followed concerning the division of cash among several banks?—W.J.A.

ANSWER: 1. This depends somewhat on the size of the hospital. In the institution with which I am associated, which has approximately 125 beds, voucher checks are approved by the administrator and signed by the treasurer or one of the other officers of the hospital. Pay-roll checks are signed by the administrator with the voucher check covering the transfer of cash to the pay-roll account signed in the manner described. There is a small account, in effect a petty cash account, called the administrator's account which is handled like the pay-roll account.

In a smaller institution with which I was familiar all checks were signed by the superintendent with no other signature required. It would seem wise, however, to have someone on the hospital staff other than the administrator authorized to sign checks so that there will be no delay in issuing checks in the absence of the administrator.

It has been my experience that when the signature of a trustee of the hospital is required it is more a perfunctory gesture than real protection against the misuse of funds. Monthly audits are real assurance to the directors or trustees that the funds of the hospital are being administered properly.

2. In a small community it is sometimes thought wise to distribute cash among several banks to avoid any feeling of discrimination. However, it is my impression that hospital business is a nonpaying proposition for the banks. Consequently, we keep all of our funds in one of three local banks. I know of instances, however, where the current fund cash for the payment of accounts payable is kept in one bank and the pay-roll account in another.—W.J.D.

Stop Infecting the Patient!

JOSEPH C. URKOV, M.D.
Pittsfield Building, Chicago

THE hospital, the doctor and the patient have equal interest in avoiding postoperative or post-traumatic infection. To the patient it means much additional suffering and expense, if not risk of life; to the doctor and hospital it is an indictment of the technics used. To the hospital it also means a lengthened patient stay, often in terms of weeks added to the recovery period; and at the present time, when hospital personnel and capacity are already overtaxed, increased hospitalization time creates a serious problem.

Infection Rate Too High

Yet the incidence of infections which occur in the hospital itself continues to be distressingly high. A patient is sent up for surgery. The operation is performed under aseptic conditions; the surgeon's technic is excellent. The wound is closed and dressed and the patient is returned to the floor in good condition, with an aseptic injury. There is no good reason why such a patient should not go on to complete recovery without complications. But there are multiple excuses for the infections which develop in too many of these cases, infections which run the scale from the stitch abscess to threatened septicemia. And the real reason—infection brought to the patient by his hospital care—is one which both hospital and doctor would prefer to overlook.

A patient is brought in suffering from a severe burn. The wound is debrided in the surgery, with proper speed and care, and dressed appropriately. The patient is carried through the difficult stages of shock and toxemia, and the wound begins to show healthy granulation tissue. Suddenly sepsis develops. The source of such infection is not, as may be claimed, the injured tissue itself. The source lies in the hospital, and the responsibility rests with it and the physician. Eradication of such hospital-borne infection would probably result in a drop in morbidity and mortality from severe burns as dramatic as the drop in mortality from shock which has been noted since the use of plasma became routine.

That is the indictment. What are the causes of hospital-borne infection and what are the remedies?

They are simple. This article is not going to develop any Utopian dreams of individual sealed surgical units for each patient, each to have its own air supply and medical and nursing staff. It will not discuss even some of the more practical and highly desirable plant equipment and modifications of floor plan which the hospital architects and engineers have developed. It will simply point out two major breaks in aseptic technic, observed in the average hospital, which can be remedied by care and foresight.

The first break is chargeable directly to the physician—too early and/or too frequent inspection of the wound or injury. For some reason or other, one of the most difficult things every surgeon must learn is that once a major wound, whether surgical or traumatic, has been properly treated and dressed it should be left alone, usually for from ten to fourteen days. Unfortunately, some surgeons who have not yet achieved this knowledge are in quite active practice.

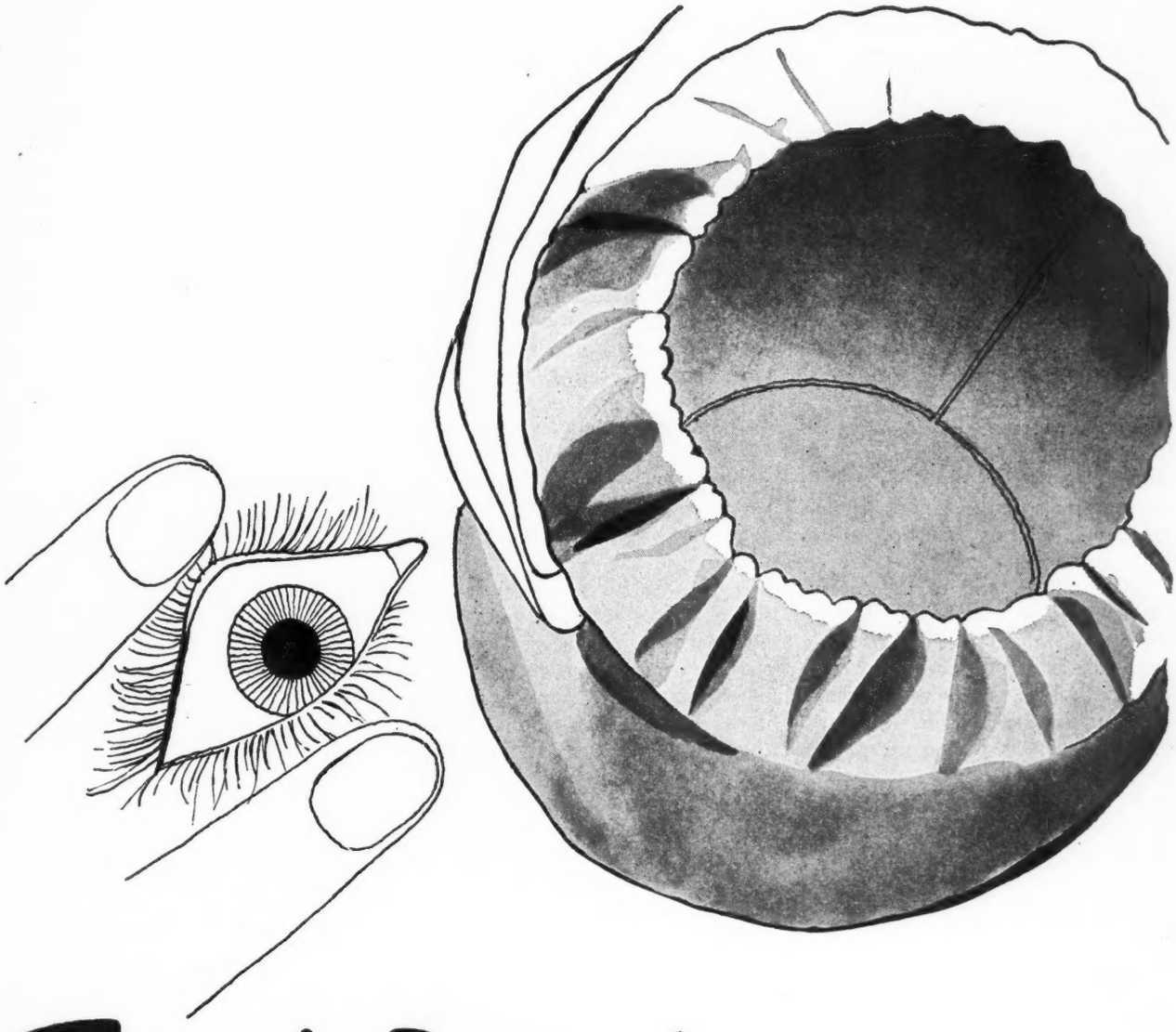
When the late Dr. Joseph B. DeLee started his practice in Chicago many years ago, he began a fight for hospital care of obstetrical cases and for education in obstetrics which is a classic in medical history. Once he was able to persuade a few patients to accept his new and wild ideas and to leave their homes for delivery and post-partum care, he was able to demonstrate that labor and the puerperium could be made safe for the great majority of both mothers and babies.

While Doctor DeLee's success was partially due to improved management and strictly obstetrical technics, the keystone was always asepsis. The lying-in hospitals and rigidly isolated obstetrics departments of general hospitals today are monuments to Doctor DeLee's battle. And in practical obstetrics, what does asepsis mean? It means that the mother has a wound and that the wound should be left alone once the necessary surgical measures are completed. It means that the course of labor is observed indirectly by rectal examination, rather than directly by the vaginal approach. It means that during the puerperium dressings are changed with aseptic precautions.

Pad Causes Contamination

For those who suggest that the previous bacterial population of the patient is the source of postoperative infection, it might be well to ponder the topical location of the obstetrical pad, which offers such an extraordinary opportunity for contamination. Yet infection does not occur if the obstetrical wound is not tampered with and if no outside source of infection is introduced. The bacterial flora native to the patient are not those to be dreaded, for resistance to them is already established.

Today if, as happened recently at a leading medical school, a hapless junior medical student mistakes the orifice and makes a vaginal rather than a rectal examination of a pregnant woman, he becomes an object of some hilarity and considerable contempt to his fellows. No reputable obstetrician would examine a woman vaginally during labor or the puerperium "just to see how things



Still the Standard

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*Zentgraf, L. P., and Eversole, V. H.: Medical Progress: General Anesthesia: New Eng. J. Med. 229: 437 (Sept. 9), 1943.

MANUFACTURING CHEMISTS TO THE MEDICAL PROFESSION SINCE 1858

were getting on." Yet many surgeons have no qualms whatever in removing dressings to inspect the progress of healing in a surgical or traumatic wound within the first critical ten days.

Their urge to pull away dressings is as intractable and of about the same quality as the urge to assist the peeling of a severe sunburn. Such premature interference may increase the degree of a burn, destroy or check the proliferation of new skin or of scar tissue and open the field to outside infection.

So much for the first major break in technic. The second is chargeable both to the careless physician and to the hospital routine which permits his errors to bring infection to another doctor's patient.

It should be, and to the careful physician is, axiomatic that the removal and replacement of a dressing should be as aseptic as was its original application. Yet what happens?

Let us assume that Dr. A, a careful surgeon, has performed proper debridement and dressing of a severe burn and has successfully brought the patient through the stages of shock and toxemia. On the tenth day he decides to remove the initial dressing, inspect the area and redress it.

Doctor A Maintains Technic

Our conscientious Doctor A comes to the bedside properly scrubbed, gowned and masked. The dressing cart is wheeled in; the patient is draped. Working rapidly and carefully, Dr. A removes the original dressings, using scissors, forceps or other instruments as required, and places the soiled materials in the bag on the side of the cart.

Noting with satisfaction the clean, healing wound surface, the doctor performs necessary debridement, selects the ointment or solution of his choice from the array of jars and bottles on the cart and applies a fresh dressing, using gauze strips, pads, cotton waste material and bandages from the various containers. All of these instruments, medicaments and supplies have been marked "sterile," and Dr. A leaves with the assurance that the prognosis is bright for the patient and that all precautions have been taken to avoid contamination of a surface already showing healthy granulation tissue.

But what has actually happened? In reality an ordinary kitchen spoon would have been more sterile than most of the materials on the dressing cart. The trouble is that Dr. X had just finished dressing a wound, using that same cart, before Dr. A came in.

Now, Dr. X is a good "surgery surgeon," but it has never occurred to him to bother about the details of postoperative care. When he came in on this particular morning he scrubbed perfunctorily, for he had been delayed on a call to see a patient with a severe throat infection and he was already behind schedule. Perhaps he did not even bother to wear a mask. He hurried to his patient's bedside and the dressing cart was brought in. He removed a soiled dressing and flipped the debris toward the bag on the end of the cart. In the course of selecting instruments, medicaments and dressing materials he made several breaks in technic which he might deplore in the surgery but which he disregards in such a minor matter as a mere change of dressings. By the time he has finished with the dressing cart he has furnished it with a liberal and varied assortment of bacteria from his hospital patients, his house calls and his own personal flora.

If Dr. X should stop to mediate on his sins of omission and of commission, he would probably concede that they existed but would claim absolution in bacteriostatics. The introduction of such agents as penicillin and the sulfonamides has not been an unmixed blessing. Rather than being properly considered as welcome and often indispensable safeguards and adjuncts, they are too often regarded as substitutes for asepsis. Their very effectiveness is thus a boomerang.

If only the patients of Dr. X suffered as a result of his laxity, there might be hope that justice would catch up with him on the basis of his high rate of infection as compared to such men as Dr. A. But unfortunately not only his patients but also those of Dr. A are the victims.

The answer to this problem is the use of the individual dressing packet.

The attending physician should write down in advance, on the hospital chart, his orders for dressings and the time at which they will be required, in exactly the same manner as he notes on the record the drugs or the fluid therapy to be used. Thus he might note "burn dressing" or "skin graft dressing, wet pack." At the time a dressing is to be changed, the dressing cart is brought in, but instead of the motley general assortment of materials it contains only individual packets, each marked with the name of the patient for whom it is to be used.

Such a packet should be prepared in the surgery, not on the floor, and might include, for example:

- Sponges
- Applicators
- Tongue depressors
- Roller gauze
- Towels
- Instruments
- Preferred medicaments in necessary quantity

In preparing the packets, the sterile materials are assembled on a tray or on a cloth wrapper. They are marked with the patient's name and again sterilized and are then routed to the floors. If desired, standard packets may be made up well in advance.

Naturally there will be variations in the types of dressings used by various staff members, but each should submit to the surgical supervisor a list of what is to be included in his standard packets. If in some special case a variation in routine is required it is a simple matter to provide for it by some such notation as "burn pack, plain petrolatum instead of sulfathiazole ointment."

Making Lists Induces Caution

The preparation of these lists is in itself a healthy stimulus to greater precision in postoperative care. The types of dressings in use must be evaluated and technics must be standardized. When some standardization has been established, it is much easier to determine their clinical effectiveness and to evolve improvements. If Dr. A has been arguing with Dr. B over the value of a particular type of dressing, it will be much simpler to determine the winning argument if Dr. X is kept out of the picture.

An example will show the type of improvement that may be devised. Grease dressings are ordinarily prepared at the bedside by smearing gauze with supposedly sterile ointment from a large jar on the dressing cart. This is a process which can best be described as extremely messy. It is also conducive to in-

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**Rochberg, S.: Anesth. & Analg. 22:174, 1943.*

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fection because it is time-consuming and involves the use of the common ointment jar, opened and shut by many hands.

We have found that strips of gauze already impregnated with ointment furnish a uniform, rapidly applied and truly sterile dressing. To prepare these, all materials and equipment are sterile and preparation is carried out under aseptic conditions. Gauze strips are placed in a porcelain dressings tray and a quantity of the preferred ointment is placed on top. The tray is then covered and placed in dry heat for a short time, in order that the ointment may melt and permeate the gauze. Such trays of gauze are not only prepared for routine dressings but also kept at hand for emergency use in the initial dressing of burns.

Whether or not the prepared dressings are used, the common ointment jar should be relegated to the scrapheap. Small tubes not only are less liable to contamination but are far more convenient. Small bottles or jars may be used for the necessary liquids.

Once the use of the standardized packet is begun in any hospital, its value will become apparent and the interested staff members and hospital employes will find it possible to work out many improvements in detail to meet individual needs.

The procedure does not require special equipment or personnel. It does require planning, care and some shifting of routines. It should not require additional over-all expenditure of time, for by centralizing and standardizing the preparation of materials greater efficiency is attained. Random preparation of instruments and supplies on the floors is frequently a source of contamination in itself. When the work is done centrally and directly under the surgical supervisor, the word "sterile" regains its meaning and ceases to be merely a soporific label.

For the sake of hospital, patient and doctor, we urge the avoidance of hospital-borne infection by (1) abstinence from too early and too frequent inspection and (2) adoption of individual dressing packets as a standard postoperative routine.

The Pharmacy's Stock Is Too Low

D. O. McCLUSKY JR.
Chief Pharmacist and Assistant Superintendent
South Highlands Infirmary, Birmingham, Ala.

THERE is no end of variety when it comes to the types of hospital pharmacies extant today. They range from the small prescription room, handling only stock drugs, to the large and elaborate installation having its own manufacturing department, with testing laboratory and sterile solution room.

In spite of the multiplicity and variety of problems, hospital pharmacists everywhere have one common problem, the improvement of standards and the elevation of the profession of pharmacy.

Let's Start Right Now

We must begin now to engage in the activities that will improve the standards of pharmacy. There are many steps we can take and procedures we can initiate to accomplish this purpose.

Better professional relations with the medical staff can be attained by having the pharmacist attend and, insofar as possible, participate in staff meetings. The American College of Surgeons states that there should be a pharmacy committee on the staff and that the pharmacist should be secretary of that committee. This recommendation is included in the A.C.S. "Manual of Hospital Standardization" and yet entirely too few hospital pharmacists have taken the little initiative necessary to point out this fact to the administrator and to the president of the medical staff with the request that this action be taken.

Such participation in staff activities would certainly do much to increase the medical profession's respect and admiration for the profession of pharmacy. Through the activities of this committee should be developed a hospital formulary, one of the greatest methods whereby pharmacy can be placed on an equal professional plane with the practicing physician.

The formulary, however, should not be allowed to become dead and obsolete, as this would offset any good accomplished by its establishment. An active pharmacy committee with its pharmacist-secretary to act as a sparkplug should have little trouble keeping the formulary up to date.

Educational facilities must be developed in every way possible, to the extent that postgraduate and refresher courses will be available to all who desire and need them. We should insist that courses in hospital pharmacy be instituted in the school of pharmacy. A familiarity with medical and hospital terminology and procedures would certainly be of advantage to all pharmacists, hospital or otherwise.

Pharmacy Internships Needed

Pharmacy internships should be established in all hospitals that meet adequate standards. This is an important step to ensure that the hospital pharmacist of the future will be an individual of the highest caliber, well trained and imbued with the spirit of progressiveness so evident in some of the national leaders in hospital pharmacy.

Education can be furthered indirectly by several other methods. Refresher courses should be con-

ducted for pharmacists by the schools of pharmacy and, in turn, such courses should be held by the pharmacists for nurses and interns. Nursing groups certainly are always receptive to such subjects as metric system, arithmetic of drugs and solutions, materia medica, pharmacology, posology, toxicology and other related subjects.

The pharmacist in a large hospital should present lectures before intern groups on newer drugs and their action, as well as lectures designed primarily to stimulate prescription writing and to promote better mutual professional respect.

By all means the pharmacist should act as instructor of pharmacology in the school of nursing, as he not only would be performing one of the primary duties of a hospital pharmacist but would have at his command the best possible method of developing respect and cooperation from student nurses.

Too many pharmacists in leading hospitals evidence a complete lack of interest in the work of their professional association. Perhaps some consider themselvs sufficiently well informed that they would receive no benefit from it. This, of course, is a complete misinterpretation of the facts. Directly or indirectly, every professional person receives benefit from association work, regardless of his education or experience. It would even be logical to assume that the better the background of the individual, the more benefit he would receive from association with others.

Often the pharmacist feels that he has reached the peak or has gone as far as possible in his institution. He feels that certain physical factors, such as limited space available, maximum number of hospital beds and size of town, prohibit progress beyond a certain point. Yet, if we analyze the situation properly most of us will find that the chief limiting factor is our own unaggressiveness and lack of initiative.

With proper cooperation from administrative heads, the potential possibilities of the pharmacy are just as big as the individual in charge of the department. The scope and extent to which the department is developed are in almost all cases a direct reflection of the ability and progressiveness of the department head. What must we do to remove the limiting and inhibiting factors that have kept us in the background all these years?

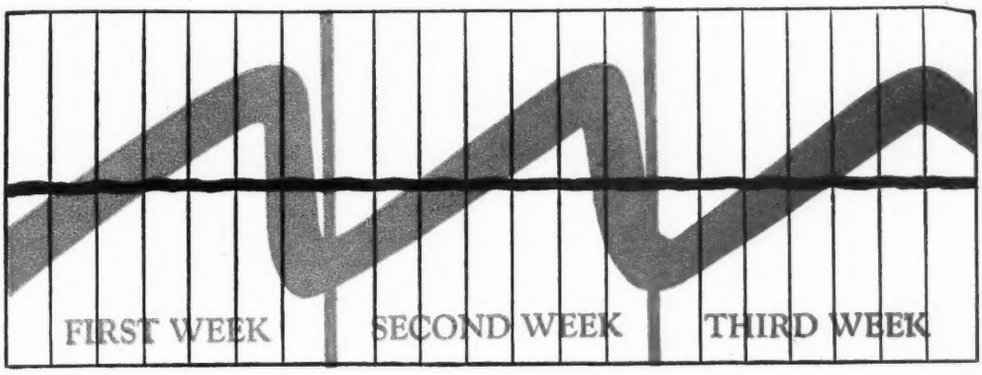
The answer in most cases is association work and activity. This permits a broadening of the individual which, in the long run, will bring about a broadening of the department and its service. Active association with others engaged in similar work is conducive to a free exchange of ideas, a better knowledge of what others are doing and how they are handling various problems.

It is a direct responsibility of the hospital pharmacist to himself and his hospital to be a member of both local and national hospital pharmacy associations.

What steps should be taken by pharmacists as a group to improve hospital pharmacy? To what extent can we expect regulation of standards of pharmaceutical service in hospitals? Who is to set these standards and what provisions for enforcing them should be established?

These are all questions that the future will answer—and that answer will depend, for the most part, on our own individual effort, *now*.

AVOIDS DISTRESSING FLUCTUATIONS



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*Conferences on Therapy: N. Y. State J. Med. 44:280, 1944.

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Administration of Penicillin

BRADFORD N. CRAVER, M.D.

University of Rochester, School of Medicine and Dentistry
Rochester, N. Y.

THERAPY with penicillin has two shortcomings that it would be desirable to overcome. First, penicillin is rapidly excreted by the kidneys, which requires the administration of more of the drug than would be required were it excreted more slowly. Second, it must be given by injection since the gastric acid destroys it; not only is this an annoyance to the patient but it almost requires hospitalization during a course of therapy.

In the last two years many attempts have been made to overcome these difficulties and some of them merit study and more extensive trial. These attempts in general fall under three headings: (1) efforts directed toward delaying the excretion of the penicillin; (2) efforts directed toward circumventing the destruction by gastric acid of orally administered penicillin, and (3) efforts directed toward delaying the absorption of injected penicillin and so prolonging the interval between injections.

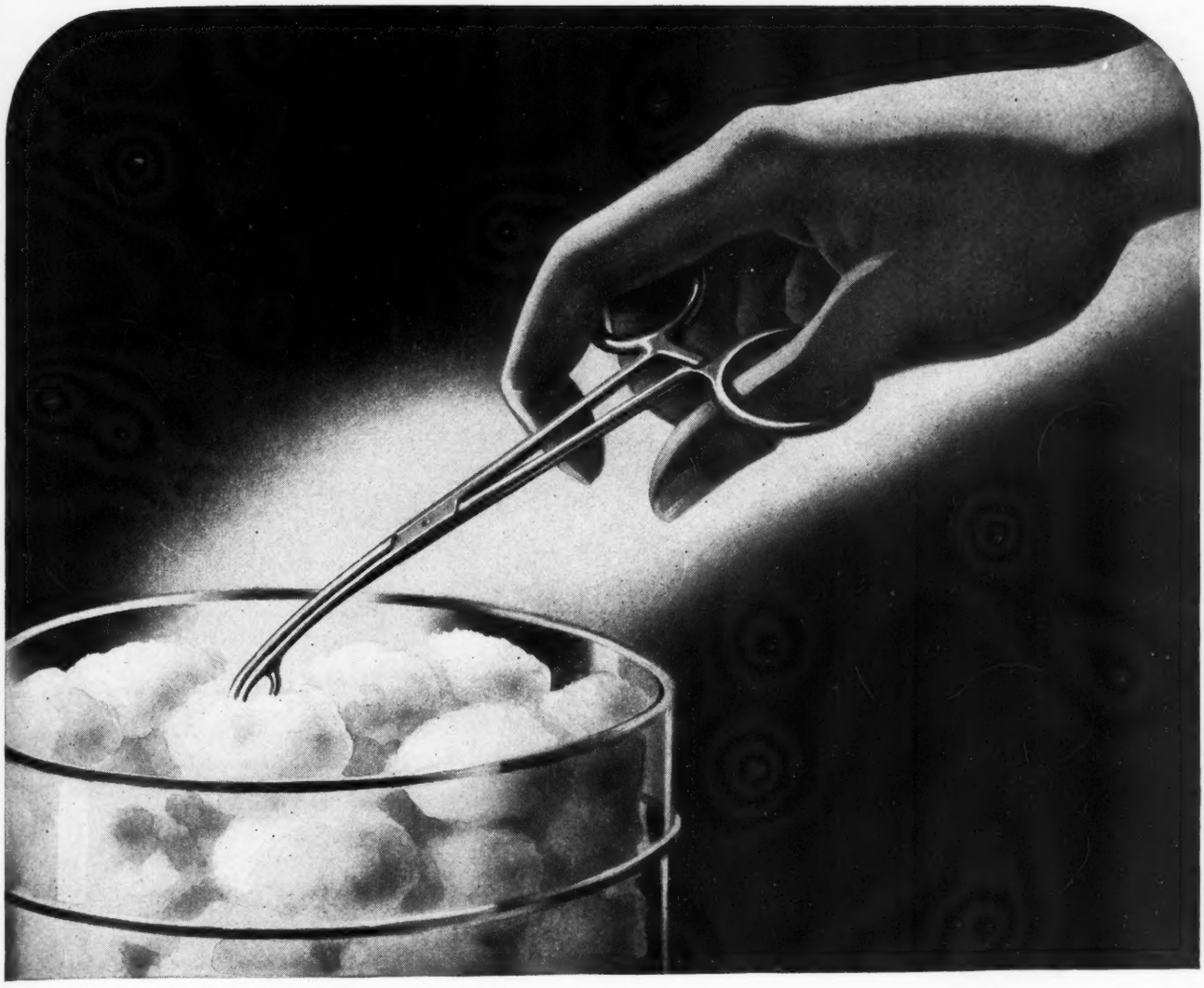
A paper by Loewe and his co-workers (1945) that does not fit into any one of these three categories is worth mentioning. They administered rectally to 14 different subjects penicillin mixed in a suppository of cocoa butter. Since they attained in all but two subjects effective blood levels, which persisted in two patients as long as twenty-four hours, they deemed this method of administration worthy of more extended trial. They used large doses, however, varying from 300,000 to 1,000,000 units, and in their five ambulatory volunteers (the other nine were recumbent hospital patients) obtained uniformly poor results.

These findings accord with those of Rammelkamp and Keefer (1943) who reported poor and uncertain rectal absorption and found that the urinary excretion of penicillin so administered averaged only about 10 per cent of the given dose. Whether these results were due to poor absorption or to an excessive destruction of penicillin in the rectum was not decided. Rectal administration would thus appear to have no advantages.

Several methods of delaying the urinary excretion of penicillin have been proposed. Rammelkamp and Keefer (1943) were the first to offer such a method. They injected diodrast with the penicillin and so obtained active blood levels for a significantly greater period of time than would otherwise have been the case, presumably by setting up a competition between the two drugs for excretion by the renal tubules. Such procedures might have proved life-saving when penicillin was scarce but would be undesirable today not only because of the expense of the added drug but because its injection has also caused death.

Beyer and his associates (1944) reported the use of para-amino hippurate to delay the renal excretion of penicillin by a mechanism analogous to that just described. The use of an additional drug for blocking purposes would appear to have little advantage now that penicillin is more readily available although, as in the case of diodrast, the results shed interesting light on the mechanism of the renal excretion of penicillin. Since they gave the drugs by venoclysis the annoyance to the patients would remain.

Many procedures have been proposed



"Post-op" Protection

Antiseptic cleansing of the skin around a wound, prior to reapplying post-operative dressings, takes a lot of care. Certainly it's no place to gamble on alcohol purity! Even the slightest irritation of the sensitive skin around the wound would retard the patients recovery.

An easy way to be certain that the alcohol you use is safe – free from all harmful irritants like aldehydes and methanol – is to always specify U.S.I. Pure Alcohol.

Painstaking control and supervision of the manufacturing of U.S.I. Pure Alcohol, and twelve rigid tests, insure the purity and absolute uniformity of this superior product. Hospitals the country over know that U.S.I. Pure Alcohol must pass tests which meet or exceed U.S.P. standards for purity. That is why they specify U.S.I. Pure Alcohol for every one of the 21 important hospital uses for alcohol.

FREE FROM FORMALDEHYDE

Here is one of 12 important tests regularly made on U.S.I. Pure Alcohol. A 50 per cent solution of alcohol is treated with a mixture of an aqueous solution of phloroglucinol and sodium hydroxide. If the alcohol is free from formaldehyde, the mixture develops no red color. This is a highly exacting test – and one more reason you can count on U.S.I. Pure Alcohol for the highest purity obtainable.

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U.S.I. PURE ALCOHOL ANTISEPTIC VEHICLE REAGENT

Partner in Medical Progress

for avoiding the destruction of orally administered penicillin by the acid of the gastric juice. Moses (1945) has reported a good "clinical response" from the oral administration of from 1 to 2 cc. of penicillin (20,000 units per cc.). He believes that such a small amount is absorbed from the mucous membranes before it has reached the destructive milieu of the stomach. This mode of administration would prove advantageous if confirmed by careful studies of blood levels and excretion but at present the amount of penicillin absorbed when so given remains unknown.

Other reports have dealt with protecting the penicillin from the gastric acid. Libby (1945) used penicillin in oil to attain this protection; McDermott et al. (1945) have employed magnesium trisilicate; Little and Lumb (1945) have given sodium bicarbonate followed by a mixture of penicillin in raw egg white; Gyorgy and his co-workers (1944) administered sodium citrate with the penicillin, and Krantz and his associates (1945) gave basic aluminum amino acetate with the drug. With all of these procedures absorption is variable and some destruction is inevitable.

The methods of delaying the absorption of injected penicillin and so extending the intervals between the necessary injections seem to offer the greatest advantages to the patient and the busy physician. Since the effects of these procedures upon excretion are purely indirect they have little effect on the total dose of the drug required for a given treatment. Now that penicillin is more freely and cheaply available the need for a method for delaying its excretion and so diminishing the total dose required for a given treatment is less urgent.

Romansky and his co-workers (1944) originally reported the possibility of injecting penicillin in oil, a method long used to delay the absorption of injected hormones. They recently (1945) reported excellent results in the treatment of gonorrhea by single injections of 4 per cent beeswax in peanut oil containing 100,000 units of the calcium salt of penicillin per cc. A single dose of 150,000 units to each of 75 patients cured all of them. Doses of 100,000 units cured 93 per cent. Such a dose maintains an assayable level of penicillin in the blood for from seven and one half to ten hours and a detectable amount of penicillin in the urine for twenty four hours or longer. This method should prove a valuable contribution to therapy with penicillin.

Trumper and Hutter (1944) delayed the absorption of penicillin by chilling the injection site with ice bags. This method would hardly be practical save in a hospital and the time and labor required would not commend it today to our short-staffed hospitals.

The value of vasoconstrictors in delaying the absorption has been reported by Fisk et al. (1945) who used 0.08 cc. of 1:1000 epinephrine per 2 to 4 cc. of penicillin and found it doubled the length of time the drug remained in the blood. Parkins and his associates (1945) obtained good results when they injected penicillin in a special 6 per cent preparation of ossein gelatine containing 0.005 per cent neosynephrine. Solutions having 20 per cent gelatine and 0.025 per cent neosynephrine appeared to have no additional advantage.

Even though penicillin is now readily available it is yet worth while to try to lessen the annoyance of injections to the patient by increasing the interval between the injections. It would seem advantageous to make available a preparation of penicillin containing the minimally effective amount of vasoconstrictor. The possibility of an interaction between epinephrine and penicillin cannot be disregarded and until it has been proved not to occur the use of a more stable vasoconstrictor of longer action would seem to be indicated.

CLINICAL BRIEFS

Conducted by E. M. Bluestone, M.D.

Summary of 13 Articles

The recent medical literature contains too much of importance to administrators to abstract fully. The following articles will be of particular interest to hospital executives:

1. Use of Red Cells in Transfusion Therapy, by A. P. Falkenstein, *S., G. and O.,* February 1945.

A discussion of the ways in which the plasma reserves of a hospital with the facilities of a blood bank can be increased by the use of red blood cells.

2. Army Contributions to Postwar Venereal Disease Control Planning, by Lt. Col. T. H. Sternberg and Capt. G. W. Larimore, *Journal of the A.M.A.,* Jan. 27, 1945.

A summary of the contributions the Army can make in venereal disease control planning, with regard to not only actual demobilization procedures, but also such activities as venereal disease education, case finding and community action.

3. Intervertebral Discs, by P. B. Magnuson, *American Journal of Surgery,* February 1945.

A short, well-balanced article on an entity which is being increasingly diagnosed and treated by operation.

4. Penicillin—Its Use in Pediatrics, by W. E. Herrell and R. L. J. Kennedy, *Journal of Pediatrics,* December 1944.

A summary of the results obtained in the treatment of a variety of bacterial infections in more than 50 cases in the pediatric age group.

5. Chemotherapy of Syphilis, by J. E. Moore, *Bulletin of New York Academy of Medicine,* January 1945.

A review of the chemotherapy of syphilis over a period of 451 years (from its first appearance in Europe in 1493 until the date of delivery of the paper, Oct. 12, 1944).

6. Syphilis—a Review of the Recent Literature, by Charles F. Mohr, et al., *Archives of Internal Medicine,* December 1944 and January 1945.

A review of the notable advances made in syphilology in the last year.

7. The Problem of Chronic Disease, by G. St. J. Perrott, *Psychosomatic Medicine,* January 1945.

The psychosomatic significance of of this article lies in the fact that the chronic diseases with which it deals are largely those in which emotional factors are of diagnostic and therapeutic importance.

8. Atypical Pneumonia, Commission on Acute Respiratory Diseases.

9. Factors in the Control of the Spread of Acute Respiratory Infections With Reference to Streptococcal Illness and Acute Rheumatic Fever, by Lt. Stafford M. Wheeler and T. Duckett Jones.

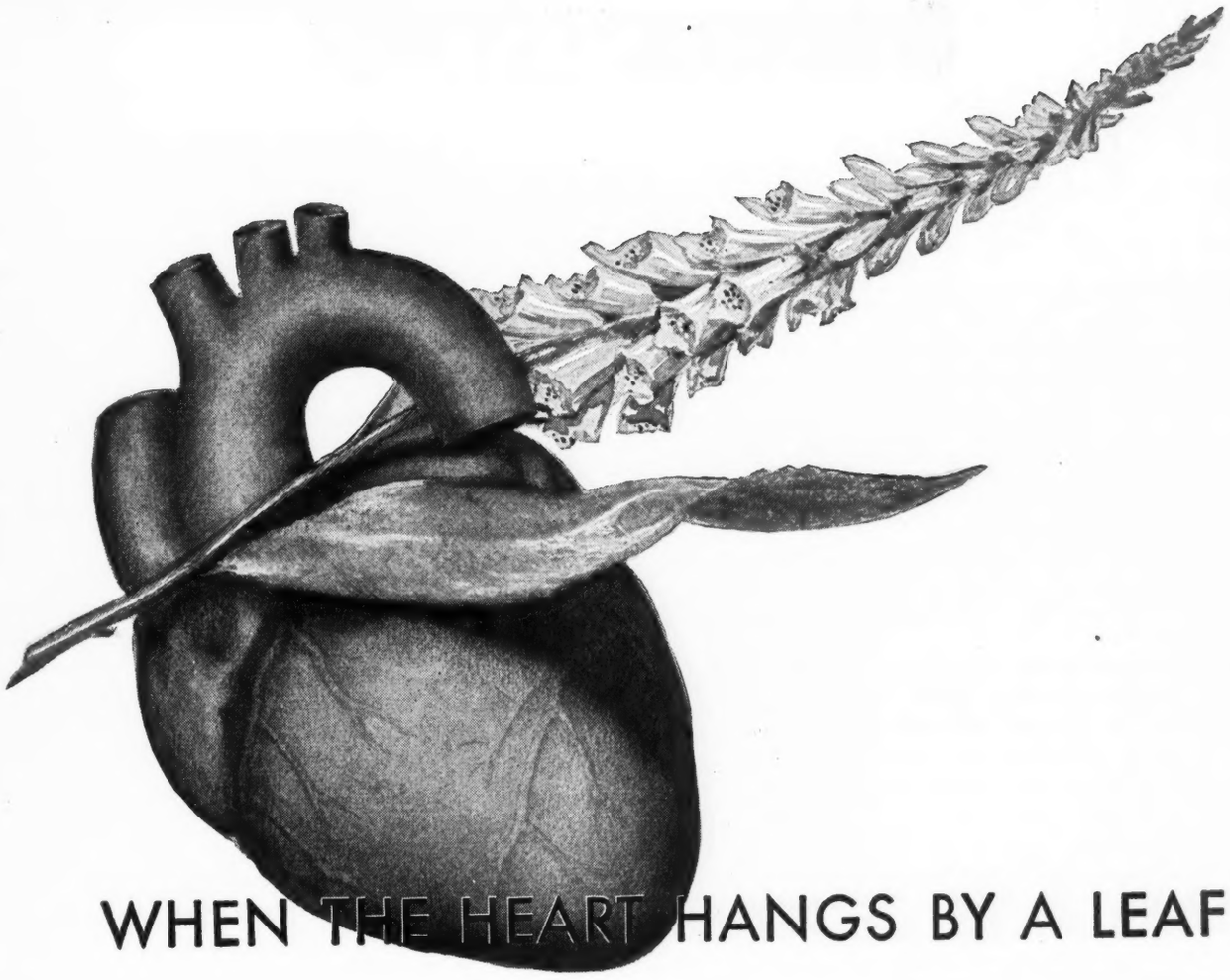
10. Scarlet Fever as an Air-Borne Infection, by Lt. Horace L. Hodes, Lt. Cmdr. Francis F. Schwentker, Lt. Beach M. Chenoweth Jr. and Lt. John L. Peck Jr.

11. The Transmission and Control of Meningococcal Infections, by John J. Phair and Maj. E. B. Schoenbach.

12. The Control of Meningococcal Meningitis by Mass Chemoprophylaxis With Sulfadiazine, by Lt. Cmdr. F. S. Cheever.

13. Mumps and Chickenpox as Air-Borne Diseases, by Karl Habel.

These six papers on air-borne infection which appeared in the January 1945 issue of the *American Journal of the Medical Sciences* were given at a symposium before a meeting of the Society of American Bacteriologists. Clinical features of atypical pneumonia and features of the epidemiologic behavior of meningitis, mumps, chickenpox, measles, scarlet fever and streptococcal infection complicated by rheumatic fever are given clarifying discussion.



WHEN THE HEART HANGS BY A LEAF

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FOOD SERVICE

Hygiene for Food Handlers

HAL G. PERRIN
Business Manager
Department of Health
Kansas City, Mo.

AFTER a lecture course given to the dietary employes of the three Municipal Hospitals in Kansas City, Mo., the following results could be noted:

1. Improved on-the-job appearance of employes.
2. Cleaner kitchens and dining rooms.
3. Better employe cooperation in the preservation of food handling technics and in the use and care of equipment.
4. A demand for fly swatters.

The dietitians, cooks, butchers, waitresses, diet maids, potwashers, dish machine operators, floor men, storeroom employes and the business manager attended the lectures and the results were so worth while that we plan to repeat the courses annually.

In-service training for dietary personnel is frequently neglected; however, in Kansas City, Dr. Hugh L. Dwyer, director of health, and his commissioner of sanitation and inspection, W. J. Dixon, base their program on the belief that education should precede legal remedy. They have made available to our employes, as well as to those of other food serving establishments in the city, a course of didactic training called the Food Handlers' Institute.

Thomas J. Laughlin, chief sanitarian, prepared the outline and lecture material and promoted the course generally in Kansas City.

A relatively fast pace is maintained and interest is kept at a high level by changing speakers frequently and by using sound and silent motion pictures, slides and stimulating quiz material.

The course is divided into two periods of two hours each, given after regular working hours (only one period per day) with a breathing spell at the end of the first hour.

Briefly outlined, the lectures are as follows:

First Period:

Bacteriology: History, nature, growth, reproduction, shapes and habits of bacteria.

Communicable Diseases: Relation of bacteria to disease; methods of disease transmittal; causes of decay and fermentation.

Medical Zoology: Spread of disease by insects and animals; life cycles, habits of insects and animals; contamination and destruction of food.

Second Period:

Dishwashing and Disinfection: Effects of various agents on bacteria; proper disinfection of utensils and equipment; proper use of detergents; application of hot water and chlorine.

Foods: Food spoilage, refrigeration and preservation; relations of animal life and bacteria to food poisoning and infection.

Personal Hygiene and Sanitation: Hand washing, restroom sanitation, uniforms, personal appearance, use of side towel.

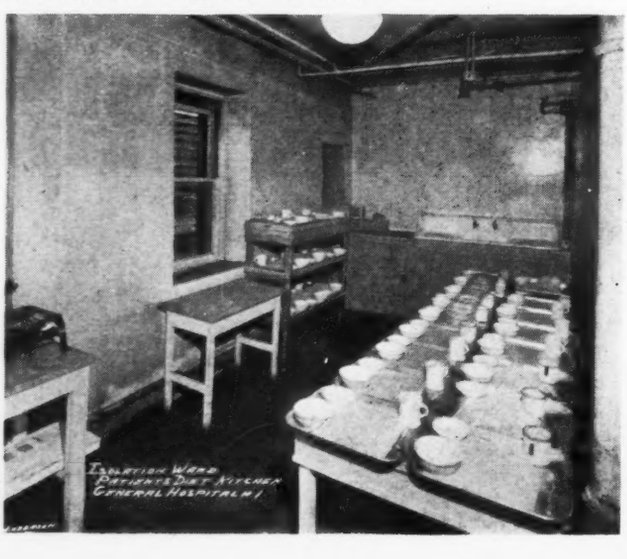
Certificates for attendance for those attending both lectures are presented at the completion of the second period.

Personal hygiene is emphasized. The admonition, "Wash your hands before leaving the toilet," is repeatedly worked into the lectures.

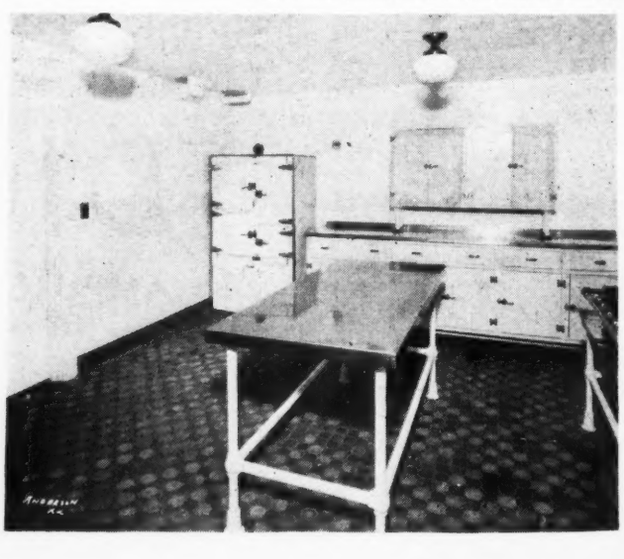
Most effective film material is "Eating Out" produced by the department of health of Flint, Mich. This motion picture, employing competent actors and actual restaurant backgrounds, compares the insanitary service at a "greasy spoon" to the appetizing and sanitary service of a well-managed restaurant.

The motion picture, "The House Fly," obtained through Erpi Classroom Films Company, Long Island, N. Y., will further intensify anyone's dislike and dread of these dis-

DIET KITCHEN BEFORE REMODELING



DIET KITCHEN AFTER REMODELING



FOOD HANDLERS' INSTITUTE—True-False Tests

Test I

Which of the following statements do you believe to be true? Which are false? Mark "T" or "F."

1. Bacteria are single celled living organisms.
2. Bacteria are too small to be seen with the naked eye and are measured in microns (1/25,000 inch).
3. Some bacteria double in number every twenty minutes under favorable conditions.
4. All bacteria are harmful.
5. Bacteria are usually placed in three different groups; oval-shaped (coccus), rod-shaped (bacillus), spiral-shaped (spirillum).
6. Bacteria do not need food, moisture and a favorable place to grow.
7. Bacteria like sunlight rather than damp, dark places.
8. Bacteria are used in many industries and are very important to crop growth.
9. Clean dishes placed in a chlorine solution of at least 50 parts per million for two minutes are adequately sanitized.
10. Clean dishes placed in water at a temperature of 170°F. for two minutes are properly sanitized.
11. There are hundreds of different kinds of bacteria.
12. One single bacterium can in a short time and under favorable conditions multiply into millions of bacteria.
13. The typhoid germ is the only real cause of typhoid fever.
14. There are at least 12 diseases that may be contracted by direct personal contact, by droplet infection or indirectly in food and drink.
15. Intestinal diseases may be spread by carriers.
16. Common towels and common drinking cups are not dangerous.
17. To prevent spread of disease, thorough washing of the hands with soap and warm water is necessary after each visit to the restroom.
18. It is possible by strictly following sanitary methods to assist materially in preventing the spread of communicable diseases.
19. Rats are not a great problem in the United States.
20. It costs about $2 per year to feed a rat.
21. Rats destroy about 10 times what they eat.
22. Rats may spread disease to human beings.
23. Roaches spread disease.
24. The house fly is sometimes called the typhoid fly because it spreads typhoid fever.
25. Presence of large numbers of flies in an establishment indicates carelessness in operation.
26. The house fly, when feeding on solid food, "vomits up" liquids from its stomach to dissolve the solids.

Test II

Which of the following statements do you believe to be true? Which are false? Mark "T" or "F."

1. Serving food free from bacterial contamination should be the chief aim of every foodhandler.
2. Bacteria are transmitted from the mouths to eating utensils.
3. A cold water rinse is sufficient to remove all bacteria from contaminated eating utensils.
4. It is quite possible to transmit infections of certain respiratory diseases, such as colds, sore throat, influenza and pneumonia, through improperly sanitized eating and drinking utensils.
5. Reserve supplies of single service utensils should be available in all eating establishments to care for peak customer loads.
6. Proper sanitizing of dishes includes thorough washing, rinsing and immersing for two minutes in water heated to 170°F.
7. It is not necessary to protect dishes in storage after they are sanitized.
8. Sanitized glasses and cups should be inverted when set upon the shelf.
9. Silverware should be placed in storage so that only the handle is grasped when removing it for service.
10. If a proprietor is unable to meet requirements for proper sanitizing dishes, he should use "paper service" containers in dispensing food and drink.
11. There are three different kinds of food poisoning.
12. Readily perishable foods, including cream filled pastries, should be stored at 50°F. or less.
13. Foods should not be displayed unless they are covered or protected.
14. Uncovered food may be contaminated by coughing and talking over it.
15. A towel used to wipe tables and counters should not be used to wipe serving dishes.
16. Floor cleaning should be done by dustless methods.
17. The safest meat to use is that freshly killed on the farm.
18. Because ice is cold, there is no need to keep it clean.
19. It is not necessary to separate and scrub vegetables before cooking.
20. Pork may transmit disease when served rare.
21. Bottles of milk, milk chocolate and orange juice should be refrigerated by covering with ice water.
22. Food infection is caused by bacteria.
23. Foodhandlers can prevent the spread of disease.
24. Rooms in which food is prepared or served should not be used for living or sleeping quarters.

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ease-carrying and food-contaminating insects.

A healthy respect is engendered for the dangers of roaches, mice, rats and the common house cat.

Administrative officials of institutions and restaurant managers are urged to attend these courses. Recently the manager of a swank Kansas City restaurant, long resistant to requests to eliminate his open sugar bowls, attended the lecture courses with his employes—and ordered closed sugar dispensers without further delay. In other cases, and more important, major kitchen improvements involving remodeling and the purchase of modern equipment have resulted.

Best and most lasting result of this endeavor, in our institution at least, comes from this acknowledgment to our employes of their essentiality in hospital service. We are convinced that one of the prime reasons for personnel turnover is the feeling of inadequacy and this short training has mitigated this problem to some extent.

Many city and state departments of health can assist hospitals in obtaining similar lectures. The U. S. Public Health Service (Bethesda Station, Washington, D. C.) is actively promoting the extension of this service.

Improved Foods
for Better Nutrition

GEORGE K. ANDERSON, M.D.
Council on Foods and Nutrition
American Medical Association

AN IMPORTANT part of the progress that has been made in the field of nutrition over the last decade lies in the studies on food composition and the nutritional status of groups of the population. These two subjects have much in common and are closely related by virtue of their cause and effect relationship.

It is not strange that a deficiency of food in the matter of essential nutrients would be transmitted to the people who use that food as a basic part of their diets. This has been observed to be the case in many studies made on population groups which depend in large part for their nourishment on foods which, for one reason of another, are of poor quality. Inferior quality may be due to poor growing conditions, such as poor soil and climate, or to deterioration during prolonged storage or transportation. These problems may be recognized and combated locally as conditions permit.

"Purified" Foods Preferred

There are other forces, as well, which have been causing a deterioration in the nutritional quality of foods on a national scale. Foremost among these is the increasing preference of the American people for highly refined foods—in particular those that retain only the smooth, light colored "purified" portions.

This trend toward the increasing use of such refined foods as white flour, white bread, smooth cereals, pastes and white sugar has been noted with grave concern by nutritionists interested in the public health. Surveys have shown that the average diet is often lacking in those substances which have been removed and discarded from the refined cereal foods. These are the B vitamins and iron. Foods of the type just mentioned comprise a substantial part of the average diet today, and they no longer supply all of the nutritional substances with which nature endowed them.

Attempts to influence taste preference back again toward the use of such basic natural foods as whole wheat bread and flour have been unsuccessful. It therefore has become necessary to devise measures to meet this difficult situation which threatened to undermine the health of the nation. The very progress of civilization that has exerted such an undesirable influence on food processing, as viewed from the nutritional standpoint, has at the same time, through technical advances in the field of chemistry, offered a means of correcting the nutritional weakness of foods.

The synthesis and commercial production of the vitamins have made possible the replacement in processed foods of the important substances that have been lost. This was the basis of proposals made by nutritionists some eight years ago. These suggestions have served as the foundation for what is now known as the enrichment program.

In its present usage the term "enriched" should be limited to those foods that have nutrients added in accordance with federal standards of enrichment. Other foods with similar substances added are designated as restored or, in a few special cases, fortified.

As the addition of nutrients to processed foods became feasible the question naturally arose as to which foods should have these materials added. This was important because the program must follow a rational course if it is to fulfill a nutritional need and should not consist of indiscriminate additions prepared for commercial exploitation. The Council on Foods and Nutrition of the American Medical Association was one of the first groups to encourage the practice of restorative additions to foods and it has always advocated that certain principles be followed in the selection of foods so treated.

First of all, the nutrients added should be limited to those which have been shown by dietary surveys to be lacking in optimal quantities in the average diet. The foods to which any additions are made should be those that naturally contain important quantities of the substances and preferably those that have suffered losses in the course of processing. Thus, a restoration can be made to the level of the highest natural quality of food of that class.

Only Staple Foods Included

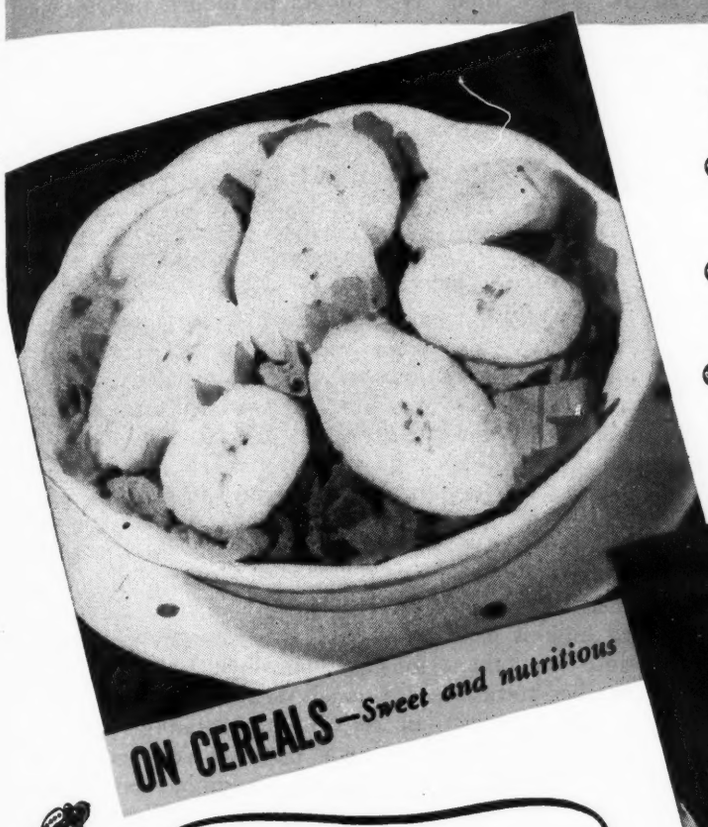
One further guiding principle has been the belief that only staple foods, or foods which made up substantial parts of the diet, should be included in the program. In this way efforts to improve foods will be directed at known weaknesses in the diet and, because of the extensive use of the foods selected, measurable benefits should be achieved.

With these policies serving as guiding principles it was obvious that white flour was one food in need of this type of nutritional improvement. For some time it had been known that the milling of wheat to white flour caused the loss of substantial portions of essential substances contained in the whole wheat.

The substances lost were thiamine, riboflavin, niacin and iron. They can be returned to the flour in the form of the chemically pure compounds and this has now been done through the combined efforts of the nutritionists and the milling industry. The same thought has been applied to white bread since this is essentially white flour.

The nutritional enhancement of white flour and bread in this way was voluntary at first. But with the advent of the war and the necessity of assuring the best possible nutrition for all, the War Food Administration ruled that all bakers' white bread and rolls must contain stated levels of these enriching substances which are essentially the quantities found in similar products made from

BANANAS...a natural sweetener



ON CEREALS—*Sweet and nutritious*

● One fully ripe banana (yellow peel, flecked with brown), average size, contains the equivalent of 5 level teaspoons granulated sugar—as follows:

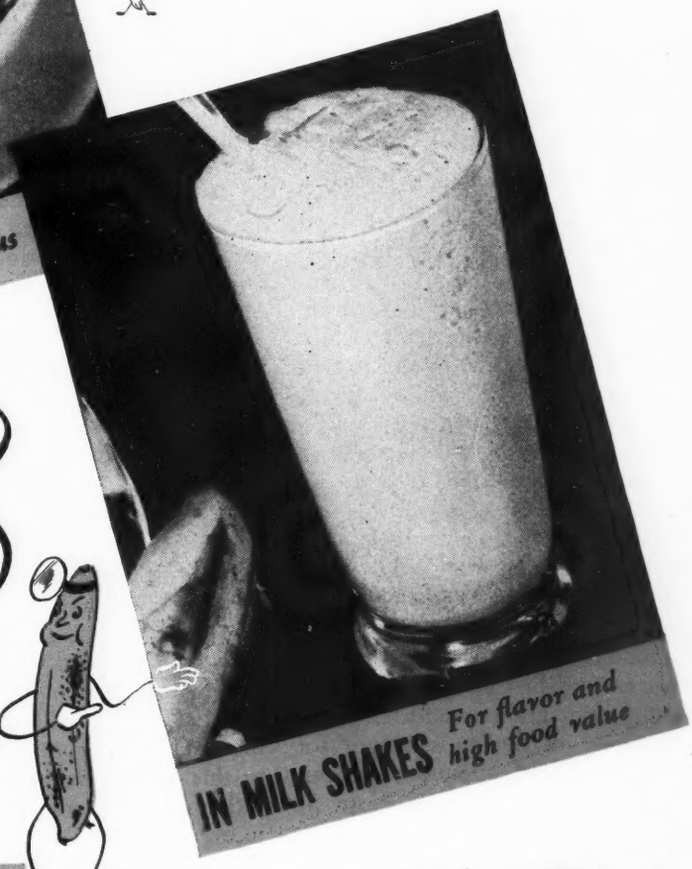
4.6% dext ose	Total sugars 20.4%
3.6% levulose	
12.2% sucrose	

PLUS

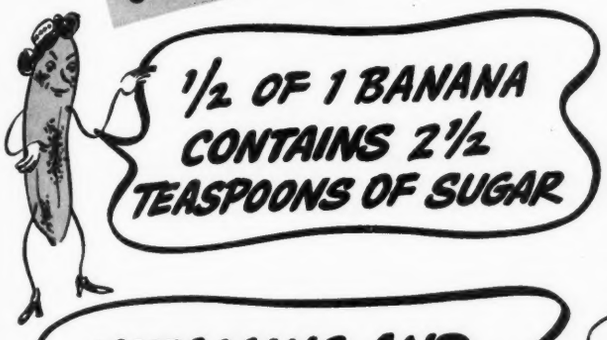
Vitamin A	310-420 International Units
Thiamin (B_1)	52-67 Micrograms
Riboflavin (G)	110 Micrograms
Niacin	.75 Milligrams
Ascorbic Acid (C)	12.5-13.7 Milligrams

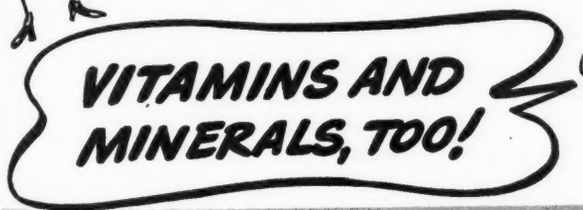
PLUS

11 Essential Minerals	120 Calories



IN MILK SHAKES *For flavor and high food value*





ENJOY BANANAS AT THEIR BEST

DO	let them ripen at comfortable room temperature.
DON'T	put them in the refrigerator because this prevents proper ripening.
KNOW	that bananas are fully ripe when the golden peel is flecked with brown.

UNITED FRUIT COMPANY

Banana Milk Shake

(290 CALORIES)

1 fully ripe banana* **1 cup COLD milk**

**Use fully ripe banana . . . peel well flecked with brown*

Peel banana. Slice into a bowl and beat with electric mixer or rotary egg beater until smooth and creamy. Add milk and mix thoroughly. Serve COLD. Makes a 10 to 12 ounce drink.

NOTE: If electric drink mixer, which crushes fruit while mixing, is used, break banana into mixer cup, add milk and mix. Add ice cream before mixing, if desired.

whole wheat. Such baked goods are designated as enriched.

At the present time most white flour is enriched but this is not required by law. It is highly desirable that the enrichment of these basic foods of our diet be continued indefinitely. Proposals for state and federal laws making this mandatory deserve the wholehearted support of every thinking citizen.

Another class of foods that suffers loss in manufacture is the processed cereals. Since these form an important part of our food consumption they should be of as high nutritional value as possible. Replacement of B vitamins and iron to levels found in the best quality of the respective natural grains is now being made by all progressive manufacturers. The cereal foods treated in this manner are designated as "restored" since they bring the important vitamins and minerals to natural grain levels.

Federal Standard for Farina

For farina only has a federal standard of restoration been promulgated. This calls for use of the term enriched when referring to restored farina. This point is actually of little import since enrichment and restoration are the same thing, differing only in the fact that in one case the standards are set by federal agencies. The result accomplished is to provide in all the foods restored in this way nutritional values comparable with the best natural foods.

Interest in programs calling for the betterment of foods by controlled addition of vitamins and minerals was centered first on the extensively used wheat grain products. With attainment of the ends sought for this type of food, attention has been turned to other weak spots in its food environment.

The milled corn that makes up a large part of the diet of certain classes of the population in the South has been shown to be in need of improvement. The same holds true for the hulled rice consumed in all areas of the country. Much progress has been made in creating interest in the need for restoring these foods to the appropriate natural values, and, at the same time, practical methods of accomplishing this have been developed and are being used.

The question of adding quantities of vitamins to spaghetti and macaroni has been raised but agreement has not been reached because of technical difficulties and the fact that the customary method of cooking these paste foods would discard most of the added nutrients which are water soluble. At the present time restorative additions to these basic foods comprise the sum total of those for which restoration is recommended.

Three other foodstuffs require mention because of the desirability of adding to each a specific food substance for a nutritional purpose. In these cases the principle of fortification is applied wherein the nutrient is added in an amount which far exceeds that normally found in the natural food.

The first of these is vitamin D milk. This usually is fortified to the extent of 400 units per quart. Milk is considered an ideal carrier of vitamin D because it supplies at the same time goodly amounts of calcium and phosphorus which depend on this vitamin for their utilization in the body. Fortified milk is particularly desirable since no other foods in the ordinary diet furnish adequate amounts of vitamin D, now recognized as an essential nutrient for children and adults.

The fortification of table salt with appropriate amounts of iodine is another nutritional improvement of decided value to the public health. The regular use of iodized salt has been proved capable of reducing the incidence of endemic goiter in all areas in which this condition is prevalent.

Finally, the third widely used food whose fortification is indicated is margarine. The addition of 9000 or more units of vitamin A per pound to this refined vegetable fat makes it the nutritional equivalent of butter in every respect. Without the added vitamin it contributes only calories and its use in place of butter may lead to vitamin A deficiency.

A wider use by the public of vitamin D fortified milk and iodized salt is to be encouraged, and vitamin A fortified margarine can be used with confidence by virtue of its fortification. There are no other widely used foods for which fortification is deemed desirable or indicated at this time.

A clear distinction should be made between the staple foods mentioned thus far as being restored (enriched) or fortified in the interest of better public health and other foods which are intended for special dietary use in the feeding of infants, convalescents and the aged or for the treatment of diseases. Foods of the latter type should be judged individually on their merits for the uses indicated. Many special products are finding valuable application in dietary treatment.

There have been other foods proposed for restoration or fortification which have not yet been recognized as suitable for this treatment. Tomato juice is one of these. The vitamin D content of this canned juice is known to vary widely and some groups interested in the problem would like to add synthetic vitamin C to standardize the juice in this respect. This is not now permitted under the law and it is not favored by many nutritionists who are of the opinion that serious attempts must be made first to grow and pack a generally improved tomato for juice.

Likewise, the addition of vitamins to sugar has been suggested as a nutritional measure. The practical aspects of incorporating vitamins into sugar have not yet been solved and little enthusiasm has been shown by nutritionists for additions of this nature to sugar or sugar products, such as candy. Any measure that will result in an increased use of refined carbohydrates is not considered nutritionally desirable.

Other Measures May Be Taken

It is probable that as our knowledge increases other measures will be incorporated into the present food-strengthening programs. It is intended that foods of highest nutritional values will be available to everyone and that good nutrition may be attained by eating a variety of the commonly used staples of the American diet, now popularly known as the basic seven.

The use of the synthetics that will be commercially available in large quantities after the war should be limited to the correction of specific deficiencies that are detected in groups of the population through the medium of restoration or fortification of appropriate foods. Indiscriminate addition of these synthetics to foods of all types, merely because this can be done at low cost, is economically wasteful, ineffective and nutritionally short-sighted.

Menus for October 1945

Agnes M. Ban
Memorial Hospital
Monongahela, Pa.

1
Apple Juice
Soft Cooked Eggs

•

Plain Broth
Roast Beef, Gravy
Oven-Browned Potatoes
Buttered Peas
Pineapple Upside-Down Cake

•

Scotch Barley Broth
Hamburger on Bun
Buttered Green Beans
Tomato Salad
Fruit Cup

2
Orange Halves
French Toast With Sirup

•

Tomato Bouillon
Baked Pork Chops, Relish
Parsley Buttered Potatoes
Cream Style Corn
Cheese Apple Crisp

•

Vegetable Soup
Potato Salad
Cold Meat
Lettuce With Mayonnaise
Peaches

3
Grapefruit Juice
Soft Cooked Eggs,
Grape Jelly

•

Beef Broth With Noodles
Meat Loaf, Gravy
Boiled Potatoes
Creamed Celery and Onions
Gelatin With Bananas

•

Cream of Potato Scup
Baked Veal Chops
Buttered Peas
Pickled Beets
Apricots

4
Stewed Prunes
Bacon

•

Julienne Soup
Roast Lamb, Gravy
Mashed Potatoes
Buttered Asparagus
Floating Island

•

Plain Broth With Lemon
Italian Spaghetti
and Meat Balls
Shredded Lettuce,
French Dressing
Royal Anne Cherries

5
Orange Juice
Scrambled Eggs

•

Cream of Pea Soup
French Fried Fillet of Cod,
Lemon Slices
Escalloped Potatoes
Buttered Green Beans
Lemon Pie

•

Cream of Celery Soup
Egg Salad Sandwiches
Sliced Tomatoes
Buttered Broccoli
Pears

6
Apricot Nectar
Soft Cooked Eggs

•

Plain Broth
Roast Veal, Gravy
Oven-Browned Potatoes
Buttered Squash
Gingerbread, Vanilla Sauce

•

Italian Brown Soup
Meat Loaf
Buttered Whole Grain Corn
Vegetable Salad,
French Dressing
Applesauce

7
Stewed Figs
Bacon, Apple Jelly

•

Vegetable Soup
Baked Ham, Raisin Sauce
Lyonnaise Potatoes
Buttered Frosted Lima Beans
Celery, Pickles
Vanilla Ice Cream

•

Chicken Broth With Noodles
Cold Meat
Molded Fruit Salad
Yellow Cake
Apricots

8
Tomato Juice
Soft Cooked Eggs

•

Cream of Tomato Soup
Swiss Steak, Gravy
Mashed Potatoes
Buttered Carrots
Chocolate Nut Pudding

•

Lentil Soup
Canadian Bacon
Baked Corn
Sliced Egg and Tomato Salad
Blue Plums

9
Grapefruit Juice
Soft Cooked Eggs

•

Tomato Bouillon
Roast Beef, Gravy
Boiled Potatoes
Buttered Wax Beans
Cornstarch Pudding
With Shredded Pineapple

•

Split Pea Soup With Ham Bone
Meat and Biscuit Roll
With Gravy
Pickles
Lettuce With French Dressing
Whipped Gelatin

10
Prunes
Scrambled Eggs

•

English Beef Soup
Breaded Veal Chops
Parsley Buttered Potatoes
Buttered Whole Grain Corn
Spice Cake

•

Beef Broth With Spaghetti
Ham and Veal Loaf
Buttered Green Beans
Tomato Salad
Peaches

11
Apple Juice
Bacon

•

Plain Broth
Roast Lamb, Gravy
Mashed Potatoes
Spinach Loaf
Applesauce Rolls With
Vanilla Sauce

•

Cream of Celery Soup
Slice of Cheese
Potato Chips
Perfection Salad
Royal Anne Cherries

12
Orange Juice
French Toast With Sirup

•

Onion Soup
Salmon Loaf, Lemon Slices
Hashed Brown Potatoes
Hot Vinegar Beets
Raisin Squares

•

Tomato Soup
Baked Sweet Potatoes
Green Beans au Gratin
Pear and Orange Salad
Plain Gelatin

13
Mixed Fruit Juice
Soft Cooked Eggs

•

Creole Soup
Roast Beef, Gravy
Oven-Browned Potatoes
Buttered Parsnips
Orange Sponge

•

Cream of Potato Soup
Hamburger on Bun
Buttered Peas
Garden Salad
Kadota Figs

14
Orange Halves
Bacon, Apple Butter

•

Rice Soup
Stewed Chicken, Biscuits
Mashed Potatoes
Buttered Green Beans
Celery, Cranberry Sauce
Ice Cream

•

Alphabet Broth
Cold Meat
Vitamin Salad
Peanut Butter Cookies
Black Cherries

15
Grapefruit Juice
Soft Cooked Eggs

•

Cream of Celery Soup
Baked Veal Chops
Parsley Buttered Potatoes
Buttered Broccoli
Blue Plum Upside-Down Cake

•

Philadelphia Pepper Pot Soup
Meat Stew With Vegetables
Pineapple and Cottage
Cheese Salad
Muffins, Jelly

16
Prunes
Soft Cooked Eggs

•

Tomato Bouillon
Roast Beef, Gravy
Boiled Potatoes
Buttered Lima Beans
Baked Custard

•

Scotch Barley Broth
Wieners With Barbecue Sauce
Buttered Asparagus
Vegetable Salad, French Dressing
Pears

17
Orange Juice
Bacon

•

Consommé Julienne
Baked Ham, Relish
Escalloped Potatoes
Buttered Peas
Cottage Pudding,
Chocolate Sauce

•

Cream of Celery Soup
Casserole of Beef, Macaroni and Tomatoes
Peach and Grated Cheese Salad
Caramel Pudding

18
Apple Juice
Soft Cooked Eggs

•

Cream of Corn Soup
Broiled Lamb Chops
French Fried Potatoes
Buttered Carrots
Fluffy Rice Pudding

•

Beef Noodle Soup
Meat and Cabbage Rolls With Tomato Sauce
Shredded Lettuce and Celery, French Dressing
Royal Anne Cherries

19
Orange Halves
Soft Cooked Eggs

•

Cream of Celery Soup
Baked Whitefish, Parsley Butter Sauce
Baked Potatoes
Green Beans
Cherry Cobbler

•

Cream of Tomato Soup
Potato Salad
Slice of Cheese
Buttered Broccoli
Blue Plums

20
Mixed Fruit Juice
Scrambled Eggs

•

Scotch Barley Broth
Baked Liver, Gravy
Boiled Potatoes
Stewed Tomatoes
Steamed Chocolate Pudding

•

Broth With Lemon
Italian Spaghetti With Meat Balls
Fruit Salad
Vanilla Wafers

21
Grapefruit Juice
Bacon, Quince Jelly

•

Plain Broth
Roast Beef, Gravy
Sage Dressing
Spiced Crabapples
Mashed Potatoes
Fried Eggplant
Ice Cream Sundae

•

Chicken Rice Soup
Cold Meat
Layered Fruit and
Cream Cheese Salad
Soft Sugar Cookies
Pineapple

22
Apricot Nectar
Soft Cooked Eggs

•

Beef Broth With Vermicelli
Baked Pork Chops
Escalloped Potatoes
Buttered Whole Grain Corn
Frosted Rhubarb Pie

•

Cream of Pea Soup
Canadian Bacon
Pancakes and Sirup
Lettuce With French Dressing
Fruit Cup

23
Grapes
French Toast With Sirup

•

Onion Soup
Meat Loaf, Gravy
Baked Potatoes
Stewed Tomatoes
Peach and Prune Upside-Down Cake

•

Cream of Mushroom Soup
Salmon Salad
Macedoine of Vegetables,
French Dressing
Buttered Asparagus
Apricots

24
Orange Juice
Soft Cooked Eggs

•

Tomato Bouillon
Swiss Steak, Gravy
Oven-Browned Potatoes
Buttered Peas
Baked Apples

•

Lentil Soup
Creamed Ham and
Hard Eggs on Toast
Lettuce With Mayonnaise
Kadota Figs

25
Applesauce
Bacon

•

Beef Broth With Rice
Roast Veal With Dressing, Gravy
Mashed Potatoes
Buttered Beets
Lemon Snow
Vanilla Wafers

•

Vegetable Soup
Hamburger on Bun
Buttered Peas
Cabbage Salad
Blue Plums

26
Grapefruit Juice
Soft Cooked Eggs

•

Cream of Celery Soup
Fried Halibut With Tartare Sauce
Hashed Brown Potatoes
Spinach With Vinegar
Apricot Pie

•

Cream of Corn Soup
Cheese Salad Sandwiches
Stuffed Celery
Tomato Salad
Peaches

27
Prunes
Scrambled Eggs

•

Creole Soup
Broiled Lamb Chops
Lyonnaise Potatoes
Succotash
Cornstarch Pudding With Peaches

•

Chicken Noodle Broth
Meat Stew With Vegetables
Lettuce With Thousand Island Dressing
Green Gage Plums

28
Grapefruit Half
Bacon, Peach Jam

•

Plain Broth
Baked Ham, Glazed Pineapple
Baked Potatoes
Creamed Cauliflower
Celery, Pickles
Ice Cream

•

Cream of Vegetable Soup
Cold Cuts
Molded Mexican Slaw
Chocolate Cake
Royal Anne Cherries

29
Apple Juice
Soft Cooked Eggs

•

Cream of Tomato Soup
Baked Veal Chops
Parsley Buttered Potatoes
Buttered Green Beans
Apple Cobbler

•

Split Pea Soup With Ham Bone
Wieners and Rolls
Buttered Peas
Lettuce With Russian Dressing
Bartlett Pears

30
Apricot Nectar
Soft Cooked Eggs

•

Beef Noodle Soup
Roast Beef, Gravy
Mashed Potatoes
Buttered Broccoli
Rice Custard With Raisins

•

Cream of Spinach Soup
Toasted Cheese Sandwiches
Garden Salad
Pineapple

31
Mixed Fruit Juice, French Toast With Sirup • Beef Broth With Rice, Broiled Lamb Chops, Pickle Chips, Escalloped Potatoes, Buttered Wax Beans, Butterscotch Pudding • Vegetable Soup, Porcupine Beef Balls With Tomato Sauce, Deviled Egg Salad, Peaches

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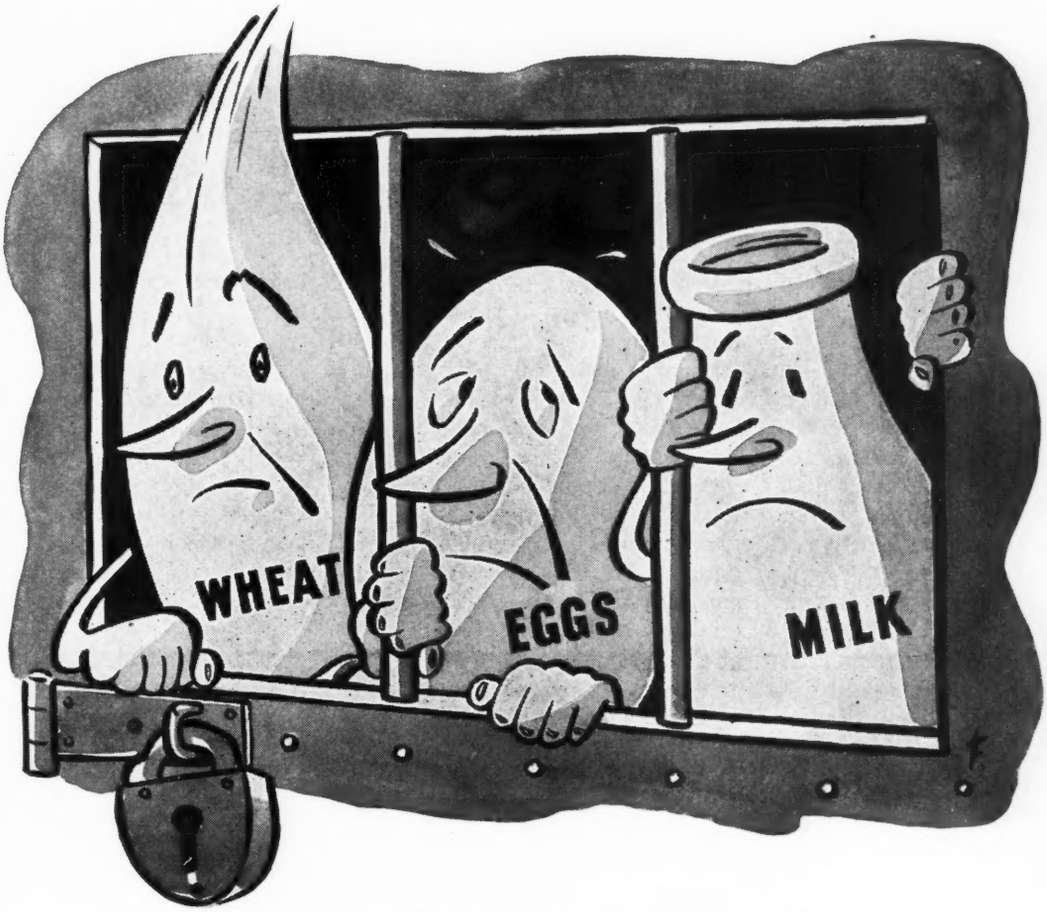
Ready-to-eat or cooked cereals are offered on all breakfast menus.



When Allergy Bars Wheat, Milk or Eggs . . .

*Remember Ry-Krisp**

Ry-Krisp solves a big problem for those sensitive to wheat, milk or eggs because this crisp-baked whole grain bread is made solely of whole rye, salt and water.

Other Dietary Uses for this Unique Bread

In Low-Calorie Diets, Ry-Krisp is helpful. It furnishes most of the essential elements of whole grain rye yet each wafer has only about 23 calories.

In Common Constipation, due to insufficient bulk, Ry-Krisp is a natural corrective. Supplies bran and minerals; also unavailable carbohydrates to encourage normal elimination.

As a Whole Grain Bread, Ry-Krisp is an every-meal favorite. Easy to serve . . . easy to eat. Economical, too. Probably the only 100% whole grain bread available nationally.

*We will furnish you, without charge, wheat, milk and egg-free allergy diets for distribution to your patients. Also, low-calorie diets—1200 calories for women, 1800 for men. And chemical analysis cards for Ralston cereals and Ry-Krisp, with special diet uses on reverse side.

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Are You Burning Coal—or Cash?

Power Plant Survey Shows the Need for Economy

EVERETT W. JONES

IT WAS our patriotic duty to conserve coal in war time. It is good business any time.

A review of articles on fuel conservation appearing in The MODERN HOSPITAL during the last twelve years indicates that our editors realized the need for fuel conservation as a money-saving possibility in hospitals long before the war emergency. When hospitals can serve their country's needs and, at the same time, add substantially to their own balance sheet through boiler room economies, it is hard to understand why many administrators have been so negligent in tackling boiler room problems.

The MODERN HOSPITAL recently sent a pictorial construction questionnaire to 2400 hospitals and to 400 hospital architects. One hundred and forty administrators, representing all types and sizes of hospitals in all 48 states, and 38 representative architects completed and returned the questionnaire up to August 6.

A study of the part of the questionnaire dealing with the boiler plant and heating system discloses some significant facts. The accompanying table gives the present thinking of those who answered all of the questions.

No administrator or architect votes for hand firing. This is fine. The recent A.H.A. manual on "Fuel Conservation in Hospitals" says (page 22), "one commentator suggests that hand firing falls 15 to 25 per cent below the efficiency of mechanical firing."

Only seven of the total of 178 replies express a preference for pulverized fuel firing equipment. This indicates a need for intensive study by hospital administrators (particularly in larger hospitals) of the possibilities in this modern method.

It is encouraging that 141 of the 178 replies (79 per cent) indicate a preference for automatic mechanical draft control. Even in a relatively small boiler plant, efficient operation is all but impossible with manual draft control. Manual draft control, like manual firing, should be mentioned only to be condemned.

Sixty-three per cent of the hospitals of 250 beds and over vote for record-

Preferences of Hospitals and Architects for Power Plant Equipment

Type of Equipment Desired	*General Hospitals*			*Psychiatric and Tuberculosis Hospitals—All Sizes*	*Architects*
	40 to 99 Beds	*100 to 249 Beds*	*250 Beds and Over*		
Number of answers	47	43	27	23	38
Manual (hand) firing	0	0	0	0	0
Stokers, coal	14	17	12	8	17
Pulverized fuel burners	2	2	0	3	0
Oil burners	25	17	11	9	19
Gas burners	10	4	8	3	15
Manual draft control	2	1	1	2	0
Automatic mechanical draft control	35	33	21	14	38
Coal scales	2	8	8	6	8
Steam flow meters	8	21	17	7	12
Water meters	10	21	10	8	10
Feed water temperature recorders	9	20	18	9	8
CO_2 analyzers and recorders	7	19	17	4	10
CO_2 hand orsat	4	2	2	1	1
Flue gas temperature recorder	10	17	17	8	8
Heating: gravity hot water	0	1	1	1	0
Heating: hot water under pressure	16	5	6	5	21
Heating: steam, regular	13	18	15	10	11
Heating: steam, subatmospheric	17	19	9	8	16
Steam flow control actuated by outdoor temperatures	5	9	9	6	12
Zone control of steam flow	10	8	10	8	26
Steam flow pressure control	6	5	3	1	2
Individual room control of steam flow	27	19	16	7	14
Operating and delivery rooms	23	28	16	6	29
Nurseries	22	28	15	5	27
Formula rooms	11	17	8	0	13
Private rooms	16	16	12	5	8
Wards	14	13	10	4	7
Free standing radiators	6	12	5	2	4
With covers	3	7	5	1	3
Recessed radiators	32	25	18	15	20*
Baseboard panel heating	4	2	3	4	0
Radiant floor and ceiling panel heating	3	4	7	1	8
Blower heaters in special areas	12	12	6	7	7

*Three architects expressed a preference for convector type of heater with hinged front cover.

FIRST IN . . . FIRST OUT

BETTER GET STARTED NOW

TO "WALK AWAY" WITH YOUR MODERN POST-WAR LAUNDRY MONTHS SOONER!

We are now actually installing some new hospital laundries. In these cases, of course, we've had the orders for some time. Manufacture of laundry equipment is no longer prohibited; but restrictions and shortages and continued production of similar equipment for government use will limit our production for some time to come.

In filling our orders, of course, it's "First In—First Out."

Why not let us help you get started now?

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ing CO_2 meters and flue gas temperature recorders. In the 100 to 250 bed group this figure drops to 43 per cent. In the 40 to 100 bed group only 18 to 20 per cent of the replies indicate a choice of these two most important instruments.

It is amazing that only 10 of 38 architects (26 per cent) indicate the need for CO_2 meters and just eight (21 per cent) vote for stack temperature recorders. This indicates rather strikingly that architects, as well as hospital administrators, could profit greatly by studying the new A.H.A. manual and paying far more attention to adequate combustion control equipment.

Although one would not expect smaller hospitals to vote for steam flow meters and coal weighing equipment, it is surprising to find only 30 per cent of the administrators from larger hospitals voting for coal scales. Interestingly enough, 63 per cent of these same men vote for steam flow meters. Measurement of steam generated and coal burned are of equal importance if one is to know how many pounds of steam are generated per pound of coal burned (the most accurate measurement of over-all boiler efficiency).

Temperature Controls Vital

All too few replies indicate a realization of the importance of modern scientific methods of controlling steam flow and, hence, building temperatures. During the last two years, I have toured more than 300 hospitals in all parts of the country. Less than 3 per cent of these hospitals have proper combustion control instruments in their boiler rooms, from which it appears that many of those who express a preference for CO_2 meters and stack temperature recorders have not yet purchased them.

The A.H.A. manual, written by Dr. Warren P. Morrill under the guidance of the committee on fuel economy, repairs and maintenance of the council on hospital planning and plant operation, should open the eyes of many administrators, engineers and trustees to the ease of saving money through fuel, steam and hot water conservation.

Dr. Frank Bradley, chairman of the council, says in his foreword, "The power plant has so long been the step-child of the hospital that it is highly probable that it now represents the one department *most susceptible* of improvement in economy in the entire hospital."

The opening sentence of the summary states that "The power plant offers the *largest single opportunity* for economy of any department in the hospital."

Between these two statements are 54 pages packed with wisdom and technical facts which every hospital administrator, engineer and trustee should study and follow. Painstaking care and thorough technical checking went into its makeup. Unfortunately, in the past, other valuable A.H.A. manuals have served only as dust collectors in hospital libraries.

Every administrator should be able to answer the following questions, all of which are covered in the manual.

1. How many tons of coal, gallons of fuel oil or thousand cubic feet of gas are burned in your hospital per year?

2. How much do you spend annually for fuel?

3. How many thousand gallons of water are evaporated or thousand pounds of steam are generated in your boilers per year?

4. Is the draft in your boilers controlled manually or mechanically (automatically)?

5. Are your boilers fired manually, by stoker (if by stoker, are they underfeed, overfeed, spreader or blower type) or do you use oil or gas burners?

6. What are the physical characteristics of the fuel now being used and do you know whether these physical characteristics are best suited to the conditions in your boilers? (Page 11 of manual.)

7. Are your boilers equipped with automatic CO_2 analyzers and do you realize the fundamental importance of checking the charts each day to be certain that the CO_2 in the gases leaving the boiler to pass up the stack is running between 11 and 14 per cent? Have you taken the time to acquaint yourself with the percentage of fuel being wasted as the CO_2 percentage drops below these figures? (Page 18 of manual.)

8. Do you understand the significance of measuring the temperatures of the stack gases as they leave the boilers? Are the boilers equipped with recording thermometers to give a day by day check of this important figure? You should know that stack temperatures are running between 450° and 550° F. (Pages 21 and 40.)

9. Do you know how many pounds of steam are being generated per pound of coal? "A pound of coal may produce as low as 3 to 4 pounds of steam under inefficient conditions, or as high as 10 or 11 pounds under efficient conditions." (Page 36.)

10. Is your hospital equipped with water-softening equipment and do you understand the importance of using boiler feed water containing from one to two grains of hardness? (Page 36.)

11. Do you have a regular summer schedule for inspecting, testing and repairing all steam traps and valves? Have you personally made rounds with your engineer to check the condition of all pipe insulation? (Page 44.)

12. What do you know about heat leakages (losses) throughout the hospital buildings? What do you know about methods of controlling steam flow (and, hence, temperatures) in various parts of the hospital? Are you thoroughly familiar with modern methods and equipment? (In addition to page 47 of the manual, study catalog and editorial reference data in the new *Hospital Purchasing File*.)

13. Are you thoroughly informed as to the method of heating and circulating the hot water service supply and what do you know about the use and abuse of hot water and steam in the laundry, kitchens and elsewhere throughout the hospital?

Let's Pay Attention to Boilers

Why not legally adopt the boiler room stepchild and give this vital part of your plant the attention it deserves?

A hospital that spends as little as $3000 a year for coal can, by careful study and judicious use of proper instruments, equipment and methods, save from $500 to $1000 a year on the fuel bill. This saving is a handsome annual return on the investment needed to make the saving. Every $5 to $9 pays for a patient day.

Hospital trustees, the general public, governmental agencies, commercial insurance companies and Blue Cross plans will become increasingly critical, and rightly so, of how we spend the hospital dollar. Let's not throw away dollars in our boiler plants.

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2. **ECONOMY**—A concentrated paste. 1 gallon mixed with water makes 1½ gallons paint.
3. **COVERS MOST SURFACES WITH ONE COAT**—Painted walls—plywood walls—wallboard—brick interiors—concrete block—building tile—wallpaper, etc.
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6. **DRIES TO A FLAT MATTE FINISH** (a) Obliterates unsightly appearance of rough, uneven wall surfaces. (b) Light diffusion without glare.
7. **JOBS FINISHED QUICKLY** — Goes on quick, easy. Covers more square yards surface.
8. **QUICK, CONVENIENT CLEAN-UP** (a) Splatters removed with damp cloth. (b) Brushes cleaned with soap, water.
9. **LASTING FINISH** — This scientifically-blended, synthetic resin and oil paint gives adequate bond and adhesion on all types of wall surfaces. Won't rub or wash off.
10. **EASY CLEANING** — with wallpaper cleaners or washed with ordinary wall cleaners.
11. **COLORS WITH EYE APPEAL** — Kem-Tone colors make any room more inviting, attractive!

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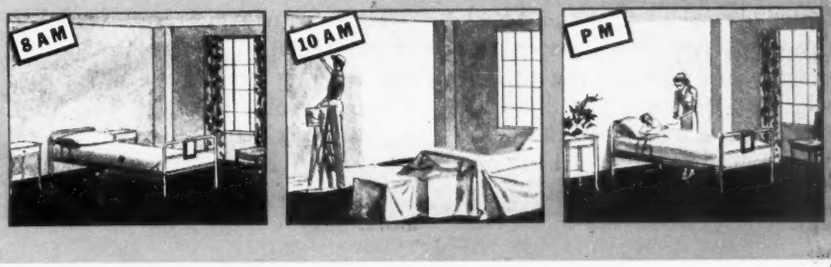


Conducted by Alta M. La Belle

DAMP SWEEPING
For Cleaner Floors

EDITH GRABAU
Executive Housekeeper
Presbyterian Hospital
New York City

IN HOSPITAL housekeeping, the maintenance of clean floors is a determining factor in the effectiveness of the housekeeping department.

Everywhere in the hospital there is the appearance of expansive acres of floor, hard and smooth surfaced, extending in broad areas in wards, stretching out to almost unending vistas in corridors, bordering the furniture in smaller rooms. When properly conditioned, all this expanse gleams back as reassuring evidence of careful cleaning which is carried through in all other phases of the housekeeper's work.

Effective results, however, are not obtained by wishful thinking. It takes approximately half of all cleaning time to keep floors properly clean. To obtain the best results for this effort is every housekeeper's wish.

Here Is an Effective Method

Damp sweeping has been found to be an effective method of floor care. In brief, it consists of wiping the floor with a damp cloth, using a special damp-sweep tool, preferably on the head of a wide hair broom, as a means of moving the cloth over the floor. It is recommended for smooth-surfaced floorings, such as linoleum, rubber, asphalt, vitrified tile, terrazzo, marble, painted concrete and smoothly troweled unpainted concrete.

The damp-sweeping method described later was developed and adopted primarily by one of the large utility operating companies as a means of safeguarding delicate operating equipment while ensuring a high standard of cleanliness.

As applied to hospital cleaning practice it has the following advantages:

1. It maintains a high standard of cleanliness.
2. It minimizes mopping and scrubbing since it effectively maintains cleanliness without these laborious methods.
3. It results in more effective use of time, if carefully taught and practiced. It achieves better results in less time than does hair broom sweeping, in both large open areas and smaller more intensively occupied areas.
4. It results in standardization of cleaning methods for all smooth-surfaced floors.

It should be noted here that damp sweeping is designed for use over areas of slight traffic soiling only. Small spots of excessive soil or spillage must be cared for individually as in any other floor cleaning method.

The damp-sweeping tool shown in the illustration (page 126) consists of a brush head with two rows of bristles 1½ inches long set at an angle around its outer edge and a 5 foot handle attached to the head assembly by means of a universal joint. This design permits raising or lowering of the handle without affecting the position of the brush head and also permits rotation of the head while in flat contact with the floor by twisting the handle.

These features give great flexibility of movement to the tool and facilitate cleaning around and under furniture and other objects. The head of the tool is lower than the head of a hair floor brush so that it readily goes under such low objects as radiators.

This damp-sweeping tool is available in sample quantities only under the present conditions. The method may be followed in most essentials by the use of a wide hair broom. The following description is based on the use of the special tool. It will be obvious that the special strokes of the tool cannot be obtained with the hair broom and the consequent limitations will also be obvious.

The sweeping cloth of light-weight muslin is about a yard square, is hemmed at the two cut edges and has a reenforced center hole. When soiled, cloths should be washed by the method described.

The following description of the damp-sweeping method is divided into functional topics and gives detailed information.

Equipment and Supplies:

Special damp-sweep tool is preferred. Hair broom (16 to 30 inches) can be used as a substitute. Pail, two-compartment type, for carrying both the clean dampened cloths and soiled cloths.

Lobby dustpan and brush.

Sweeping cloths.

Soap, powdered, dissolved in water for washing the cloths, or 1 cup of liquid soap added to a 10 quart pail of water.

Procedure in Sweeping:

Procure a sufficient quantity of the sweeping cloths to last for the scheduled sweeping without need for rewashing. One cloth usually suffices for from 500 to 1000 square feet of floor space under average conditions before rewashing. The cloths, in the damp condition resulting from the previous washing, are folded flat and packed individually in one side of a two-compartment pail so that they

will remain damp for the duration of the sweeping tour.

For sweeping waxed floors the cloths are of the proper degree of dampness when they leave the floor slightly damp when passed over it and the dampness dries within a few seconds. For unwaxed floors, *i.e.* tile and terrazzo, more effective results are obtained when the cloths are slightly damper.

Make a brief inspection of the floor to be swept and if there is visible debris, such as paper, clips and rubber bands, remove it with the lobby dustpan and brush so that it will not be necessary to "chase" the debris over the floor during the damp-sweeping operation.

Slip the center hole of a damp-sweeping cloth over the handle of the brush permitting the cloth to drape loosely over the head. Place the brush in contact with the floor with the cloth completely covering the head so that the hair does not come in contact with the floor. This is done by moving the head forward as it is lowered to the floor.

Brush Can Be Reversed

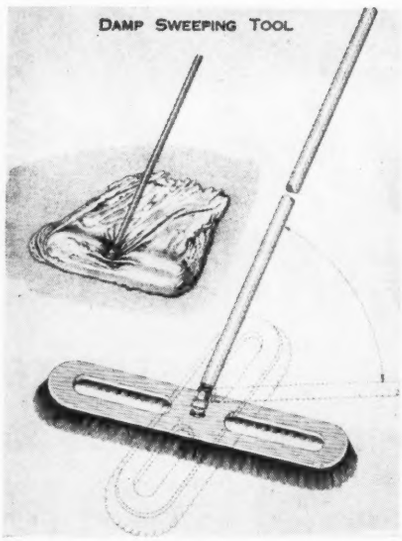
After a cloth has accumulated dirt on the forward portion, the head is raised about 1 foot and then lowered in the backward direction in order to present a clean surface to the floor. The handle of the brush is reversed so that the back edge of the brush then becomes the forward edge. When this portion of the cloth also becomes dirty or dried out, it is replaced by a clean one.

Note that this reversal is possible only with the damp-sweep tool. If a hair broom is used the cloth must be swung around.

In removing the soiled cloth, the brush handle should not be raised more than one foot from the floor and the soiled cloth should be handled carefully to avoid releasing any dirt or dust. Fold the edges of the cloth inward toward the soiled portion. Any dirt that drops from the cloth should be wiped up by hand, using the discarded cloth. Used cloths should be placed in the half of the two-compartment pail reserved for them.

When using the brush, extra downward pressure is applied to remove the embedded dust and dirt from floor surfaces more effectively.

Three different types of strokes are used in manipulating the special



damp-sweep tool to meet various conditions of sweeping, as follows:

1. The forward stroke, in which the brush head is simply pushed along in an approximately straight path, as along a baseboard or filing cabinets.

2. The side-to-side stroke, in which the brush is moved from side to side, as in mopping, across a path 6 to 12 feet wide. The head of the tool is rotated at the end of each stroke to keep the forward edge continuously in the direction of travel. When doing this stroke hold the upper end of the handle below the chest at all times. Care should be taken not to swing the brush head too violently at the end of each side stroke in order to prevent dirt or dust from being thrown off. This type of stroke is used in unobstructed areas.

3. The random stroke, in which the brush is manipulated around under desks, tables and lockers by twisting the handle so that the brush head reaches all of the obstructed floor area. The brush head is manipulated to maintain a leading edge so that any loose dirt will be carried out into open space. As the sweeping progresses from one piece of furniture to another, the front edge is held in the direction of travel.

During the course of the sweeping, clean surfaces of the cloth are presented to the floor, as described, after about 300 to 600 square feet have been swept. Cloths should be replaced with clean ones when they become dirty or dry.

Floors that have been properly damp swept will not show any dust on the tips of the fingers when they are passed over the floor in a side-to-side sweep of some 5 to 6 feet.

Washing of Sweeping Cloths:

The soiled cloths should be placed, as soon as possible after use, in a solution made in the proportion of 1 cup of liquid soap to a pail (10 quarts) of water, preferably warm, and should be allowed to soak until they are washed. However, before soaking, the cloths should be individually inspected for pins or other hazardous items and any loose dirt also should be shaken out. They should be placed in the solution individually to expedite subsequent handling and washing.

The washing operation should be done as near to the time that the cloths are to be used again as is practicable, since the final wringing operation following rinsing leaves about the proper amount of dampness for sweeping. The cloths will not mildew or become rancid in the soap solution even if soaked for several days, such as over week ends.

The washing may be done either by hand or in a washing machine, using the soaking solution or, if dirty, a fresh one of the same strength. All of the dirt is to be removed but it is neither necessary nor desirable to restore original whiteness. Rinse until the rinse water remains relatively clear. Usually two or three rinses are adequate. To determine whether the cloths have been adequately washed, let one dry completely and then shake it over a clean surface to see whether any dirt or lint is shed.

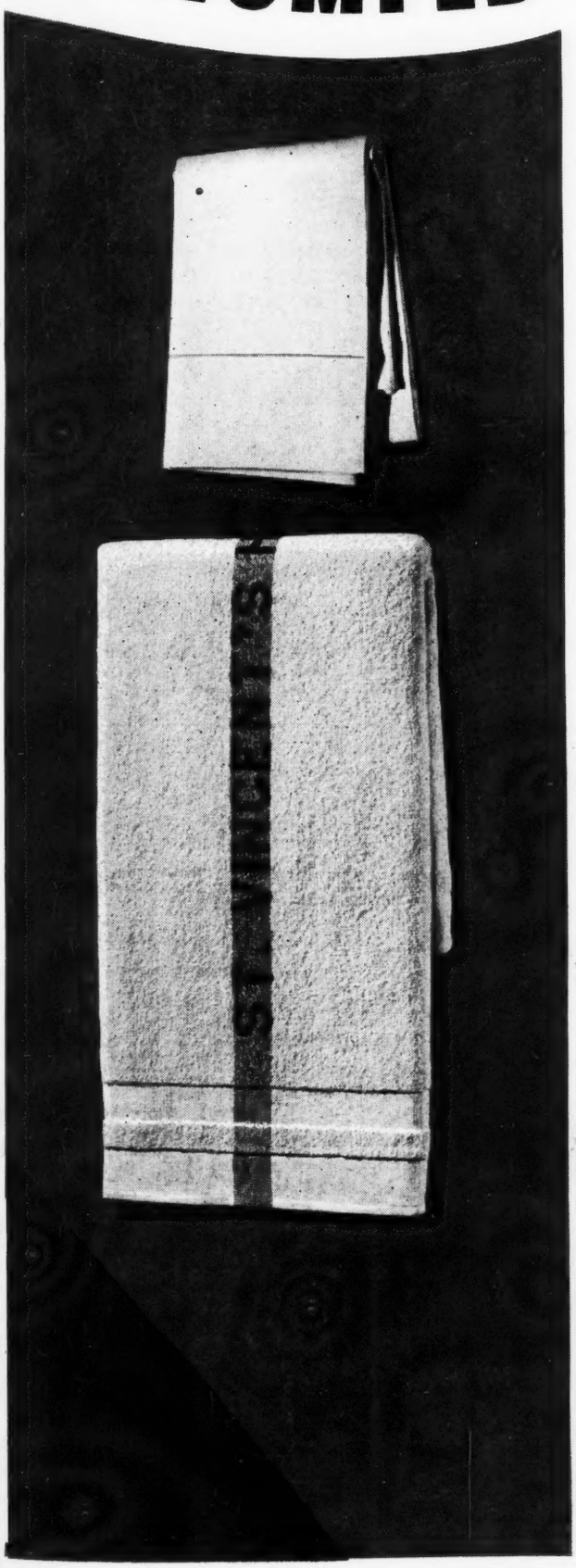
Following the washing, rinsing and wringing operations, the cloths are individually folded flat and firmly packed into one side of the two-compartment pails while they are still damp. They are then ready for use in sweeping, but cloths so packed will only retain their dampness for a few hours.

Cloths may be laundered by commercial laundries if the quantities are sufficient to warrant it. The wet-wash classification is considered adequate since drying is not required.

Care of Equipment:

After use, the pails, damp-sweeping brushes and lobby dustpan and brush should be cleaned and put away in their proper places. The damp-sweeping brushes should be hung up so that the weight does not rest on the bristles.

IS STUMPED



"Yes," says the Swami (with an ear to Washington), "you'll get electric fans and kitchen ranges and clocks and cooking pots." But when it comes to sheets or towels . . . well, neither the Swami nor *we* can tell you when there'll be all you want!

Fact is, even war's end doesn't mean an *immediate* abundance of long-needed linen supplies. That time's still ahead . . . but Cannon's bending every effort to see your orders are met at the earliest moment possible.

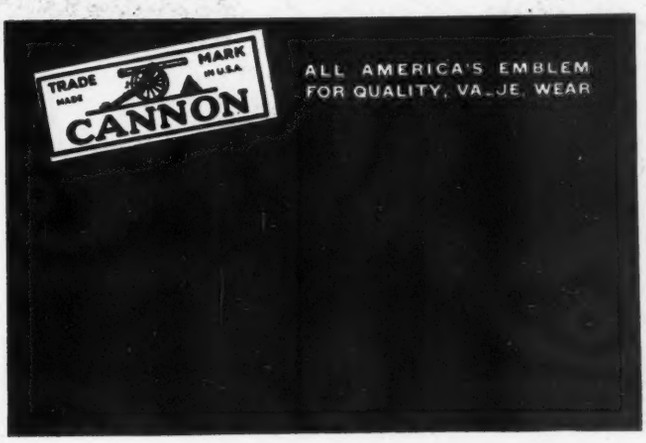
Till fresh replacements come trooping in to relieve your veteran linens, let's keep up the good work—get every one to pitch in so present stocks will "last it out" in handsome style!

Three ways to "rejuvenate" hard-working linen stocks

THE RIGHT TOWEL FOR THE PURPOSE. A hand towel at the right place saves unnecessary use of bath towels . . . costs less to launder, too. Don't use towels on sharp instruments. Wise use of cloths and cleansing tissues spares towels many tough jobs.

ROTATE TOWELS AND SHEETS to give 'em all a rest. From laundry to top of pile, from bottom of pile to use . . . that's the share-the-wear program that lengthens towel and sheet service.

FIRST AID to towels and sheets pays dividends. Prompt mending of tears, ravels and breaks adds months of service. And watch out for rough or splintered shelves and hampers. It's easier to fix them than to replace linens. Cannon Mills, Inc., 70 Worth Street, New York City 13.



NEWS IN REVIEW

O.W.I., Advertising Council, U.S.P.H.S. Launch Hospital Recruiting Program

Through the cooperation of the Office of War Information, the U. S. Public Health Service and the War Advertising Council, a national program for the recruitment of graduate nurses, volunteers and other personnel for voluntary and veterans' hospitals has been developed and was launched in August.

At the last moment the program was nearly lost because of the need to raise $10,000 to prepare necessary kits of information to be sent to the advertisers and publishers who participate in the work of the War Advertising Council. The A.H.A. appealed to Abbott Laboratories and this firm promptly made the necessary grant on August 10.

The program was started, in spite of V-J day, in the belief that hospitals will continue to need personnel for many months to come. Under this program millions of dollars worth of free radio time and advertising space will be devoted to the following objectives:

1. To persuade inactive nurses to return to nursing as long as the present emergency continues.

2. To encourage nurses in civilian hospitals, veterans' hospitals and public health agencies to continue at their jobs and to urge all nurses in nonessential work to shift to more essential duties.

3. To recruit nurses for the Veterans Administration.

4. To recruit auxiliary workers, especially trained volunteer nurse's aides and students in home nursing.

5. To appeal to the public (a) to safeguard its health as far as possible and thus reduce the load on hospitals, (b) to postpone operations and periods of hospital care if the doctor believes it safe to do so and (c) to have only such nursing care while in the hospitals as the attending physician feels is absolutely necessary.

It is pointed out that the effectiveness of this powerful national publicity will depend in considerable measure upon local ability to reap its fruits. Local and state nursing councils for war service, local, district and state hospital associations and other groups are expected to see that all inquiries are answered promptly, that applicants for employment are received courteously and referred to suitable employers.

If applicants go directly to local hospitals, it is pointed out, some hospitals will probably receive more applications than they need while others will still be short.

Propose Formation of Organization for International Health

By EVA ADAMS CROSS

WASHINGTON, D. C.—A joint resolution was introduced August 1 in the Senate authorizing the President to provide for the speedy convening of an international conference to establish a permanent international health organization. The joint resolution (S. J. Res. 89) was introduced by Senator Pepper for himself and for Senators Wagner of New York, Murray of Montana, Capper of Kansas, Ball of Minnesota and Smith of New Jersey. It was referred to the Senate Education and Labor Committee.

In discussing the nature of an international health organization, Senator Pepper indicated certain principles:

1. It should draw on the resources of all the United Nations, particularly those that are leaders in the health field.

2. It should draw on all the best experience of pioneering organizations in this field, such as the Industrial Health Service of the International Labor Office, the International Public Health Office in Paris, the Pan-American Sanitary Bureau and, above all, the health section of the League of Nations.

3. It must have suitable regional arrangements.

4. It must provide the services that the constituent nations want and need.

5. It must call on leading health authorities and other far-sighted men and women in various consultative and advisory capacities, in addition to the heads of national health services and other official government agencies.

6. It must have adequate financial support.

7. It should develop and maintain outstanding medical research laboratories, schools of public health, information activities, exchange facilities and other such services.

8. It should assist nations to obtain the personnel, medicines and supplies and information required for adequate health programs.

Navy Commends Architects

Myron Hunt and H. C. Chambers, architects, Los Angeles, were commended by the U. S. Navy for outstanding services during the war period. This commendation was the first of its kind ever awarded to an architectural firm in the Eleventh Naval District.

Red Cross and A.N.A. Cooperate on Guidance for Nurse Veterans

WASHINGTON, D. C.—The cooperative program of the American Red Cross and American Nurses' Association for assisting nurse veterans, which began operation July 1, is already showing results, according to a recent statement of the Red Cross.

The plan provides that Red Cross field directors at separation centers and chapter home service departments see that notices of separation for nurses are forwarded promptly to chapter nurse recruitment committees and to the state nurses' associations. A chapter hospitality program for released nurses has been set up by A.R.C. nursing services. Red Cross recruitment committees will get in touch with all nurses who file notices of separation and will relay the information to the American Nurses' Association.

The A.N.A. through the state nurses' associations will then assist the nurse through its counseling and placement services for released nurses.

In June, the A.N.A. announced a nationwide program of professional counseling and placement through well-organized state and district nurses' associations and the 157 professional nurses' registries in 37 states. Frances O. Triggs, formerly regional personnel consultant for the Social Security Board, clinical counselor in the personnel bureaus of the Universities of Illinois and Minnesota and dean of women at Asheville College, Asheville, N. C., was employed last fall as personnel consultant to develop the nurses' association program.

Miss Triggs has been traveling to various areas to assist in setting up the program. The nurse placement service in Chicago is being reorganized as a branch of the national office for the professional counseling and placement service.

State and local nurses' organizations are working out plans for financing the service without fees to applicants.

A list of 26 colleges and universities that offer courses in professional counseling and placement under the Bolton Act to eligible registered professional nurses has been compiled by the A.N.A. Because of the great need for nurses who are trained in these fields special effort is being made to bring these courses to the attention of all those nurses who are eligible.

Tuberculosis Study Planned

A nationwide study of tuberculosis among the Jewish people of the United States has been planned by the Council of National Jewish Tuberculosis Institutions. It will enlist the active cooperation of Jewish social service workers and physicians in determining the extent of tuberculosis and in providing hospitalization and after care. In addition, the program will disseminate public information necessary for an adequate solution of the tuberculosis problem on a national basis.

Women in Medical Service

Additional pamphlets in a series on the outlook for women in the medical services were published during August by the Women's Bureau of the U. S. Department of Labor. New pamphlets cover the outlook for medical records librarians, practical nurses and hospital attendants, medical laboratory technicians, professional nurses, occupational therapists, physical therapists, women physicians and technicians for hospital x-ray departments.

Contributions Are Deductible

Recent decisions of the federal tax court held that contributions to hospitals are deductible from income tax even though the hospitals receive considerable income from services to patients. The exemption is not impaired so long as none of the income is paid to any private individual or shareholder.

Southwest Institute on Personnel Relations Stresses Golden Rule

By W. D. BOHMAN

Approximately 50 persons, representing Texas, Louisiana, Missouri, Arkansas, Oklahoma and even New York, attended the Basic Institute on Hospital Personnel Management at the University of Houston, Houston, Tex., on July 23 to 27. Starting with the historical background of personnel management and some of the reasons for its attaining such prominence and continuing through to its future outlook, the registrants were treated to five full days and nights of helpful concrete material.

Industry played the major rôle in providing the material for the students. Considerable emphasis was placed on the importance of properly classifying and analyzing the various jobs found in an organization, from the standpoints of both worker placement and salary determination. Also stressed were the need for proper orientation of the employe to his job and to the organization as a whole and the value, both to the organization and the individual, of proper training for his particular work.

Specific examples of the service training as found in industry were portrayed. In addition, a trial study was made and presented called "Handbook for Maids on How to Clean a Hospital Room." This was done at the Hermann Hospital, Houston, Tex., and clearly presented a detailed analysis of one specific job.

Carl Flath, administrator of Charlotte Memorial Hospital, Charlotte, N. C., underlined as a prime requisite in the development of any personnel department a *master plan* reduced to writing, embodying the reasons for the project, problems to be met, practical objectives, how the department is to be set up and its relations to other departments.

Mr. Flath struck the keynote of the whole program when he stated that "good relations between employer and employe are fundamentally human relations, thriving where there is good faith on both sides with a recognition of each other's rights and interests."

Employe grievances came in for special consideration and the hospital representatives were advised as to the importance of providing opportunities for the worker to unburden his "gripes" and worries. Industry operates on the theory that by "nipping in the bud" many of these grievances, major problems and issues can be avoided.

Col. Ike Ashburn, executive assistant to the vice president, Todd-Houston Shipbuilding Corporation, Houston, Tex., concluded the formal program with some sound advice for the whole hospital field. He looks for little reduction in present pay scales and sees a trend toward shorter working hours with enough compensating pay to keep total income at present levels. Likewise, collective bargaining is here to stay. Hospitals must take care of their own employes if they do not wish any outside compulsion.

External pressure usually results when management fails to take care of its unorganized group with the same fidelity as organized groups, Colonel Ashburn declared. In the consideration of the working man the Golden Rule is the only yardstick.

In addition to the formal presentations during the day, three evening round-table discussions were held. There were conducted by Robert Jolly, Joseph Norby and Hazen Dick on successive nights.

The institute was officially closed Friday night, July 27, with a banquet and the presentation of certificates.

Hospital Given $7800

A gift of $7800 to the Litchfield County Hospital, Winsted, Conn., was announced on August 4 by Austin J. Shoneke, superintendent. The gift will be used to purchase a portable x-ray machine and new laboratory equipment.

Emerson Committee Report Recommends 1200 Local Health Units

Approximately 1200 local health units, each comprising one or more counties, are recommended in the long-awaited report on "Local Health Units for the Nation," published during August by the Commonwealth Fund for the American Public Health Association.

This method of providing local health services with full-time health officers and adequate staffs would mean a sharp reduction in the 18,000 local health offices now functioning, most of them with only part-time services.

The report was prepared by a committee under the chairmanship of Dr. Haven Emerson.

It recommends that each local health unit serve a population of at least 50,000; be composed of a county or group of counties; include the urban as well as the rural areas; provide at least one full-time medically trained health officer; employ one public health nurse per 5000 population, and have available about $1 per capita to spend on public health services.

Six essential primary services of public health should be the function of local government, the committee says. They are: (a) vital statistics; (b) communicable disease control; (c) environmental sanitation; (d) public health laboratory services; (e) hygiene of maternity, infancy and childhood, and (f) health education. In some areas, the failure to organize workable local health units "is gradually removing the intimate and personal service of local health protection from the sphere of local to that of state government."

The committee recommends state legislation whereby cities and counties may unite to form districts of suitable size.

To staff the 1200 units, the following workers are recommended as a minimum: 2060 full-time health officers and directors of medical divisions; 6145 part-time practicing physicians; 26,400 public health nurses, nearly twice as many as were employed in 1942; 5800 workers in environmental sanitation; 8930 clerks and secretaries; 3535 laboratory workers; 3790 dentists and 4265 dental hygienists; 542 health education specialists, and 2390 other workers.

In the full report data are given on the facilities in each state showing population of each unit, its area, spendable income per capita, assessed valuation per capita, general hospital beds per 1000 population and practicing physicians with number of persons per physician. Also, there are summaries of existing personnel and facilities for local health services.

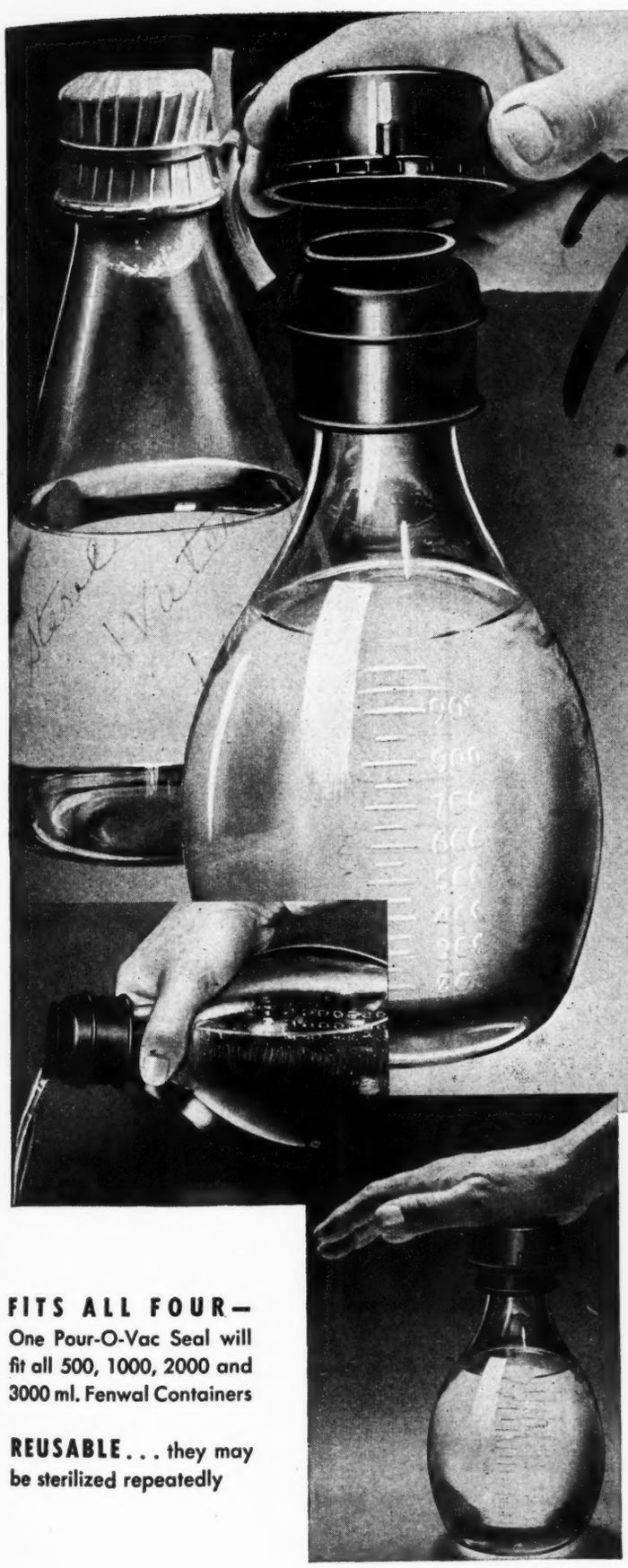
A.M.A. Opposes Bills on Research, Child Welfare

Opposition to the bills extending federal control of research and the bill affecting maternal and child welfare is expressed in the August 11 issue of the *Journal of the American Medical Association*. On the research bill the *Journal* points out that public pressure may determine the allocation of funds and that federal control might prevent the disseminating of any information and might monopolize personnel.

On the maternal and child welfare bill the *Journal* says "the public has a right to ask that need be established before funds are allocated." It also states that "the wisdom of placing control in the Children's Bureau through insistence that plans must be approved by the chief of that bureau before funds can be granted is subject to doubt."

Films Aid Cadet Training

WASHINGTON, D. C.—Thirteen motion pictures to aid in the training of cadet nurses were released by the U. S. Office of Education on August 11. All of them were produced in cooperation with the U. S. Public Health Service and with various hospitals and nursing groups. The films are on 16 mm. sound tracks. Instructors' manuals are available without charge.



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Cleveland Hospitals Join in Combined Fund-Raising Drive

The Greater Cleveland Hospital Building Fund has been chartered by the state to conduct a fund-raising program for between nine and eleven million dollars. This will provide four new hospitals and enlarge 13 others in Greater Cleveland. Goal of the public campaign will be $9,525,000. There is now available $2,560,000.

The campaign will start about January 1 and run until June. Large industrial contributions will be sought in November and December. The program is sponsored by the Joint Hospital Planning Committee of the Cleveland Welfare Federation and the Cleveland Hospital Council. It represents four years of study of ways to meet the need for more hospital facilities.

Robert S. Bingham, chairman of the committee says, "I believe this plan is the most efficient way of appealing for the needed funds. If each hospital involved conducted a campaign of its own, estimates proposed to us showed that the money sought would total nearly twice what we are asking."

One of the four new hospitals is to be built in Euclid where citizens recently proposed a million dollar campaign for their own hospital. New hospitals will also be built in Cleveland southwest and central sections and in Garfield Heights. Existing hospitals included in the expansion program are: Evangelical Deaconess, Lutheran, Grace, Huron Road, Mount Sinai, St. Alexis, St. Ann, St. John's, St. Vincent Charities, University, Woman's, Polyclinic, St. Luke's and Fairview Park.

It is the first time in this country that a group of hospitals has joined together in a single campaign to raise so large a sum. The plan will provide 1174 additional beds and also greatly enlarge diagnostic and laboratory facilities. Will, Folsom and Smith of New York has been retained as professional counsel.

The Greater Cleveland Hospital Building Fund is a nonprofit group and is now being chartered to conduct the fund-raising program on behalf of the voluntary hospitals. The following leading industrialists have been asked to advise on leadership for the plan: Sam W. Emerson, president, Sam W. Emerson Company; Percy W. Brown, resident partner, Hornblower & Weeks; Charles J. Stilwell, president, Warner and Swasey Company; W. T. Holliday, president, Standard Oil Company, Ohio; Herbert T. Ladds, president, National School and Manufacturing Company.

The Academy of Medicine and the Cleveland Hospital Council have agreed that the expansion program will meet the minimum postwar needs of Cleveland. The plan has also been unanimously approved by the trustees of the Welfare Federation.

New hospitals to be built in Euclid and West Park will each cost $1,200,000. An inter-racial hospital will cost $600,000. The Sisters of St. Joseph of the Third Order of St. Francis have $250,000 available for the $600,000 hospital to be built in Garfield Heights.

All of the existing hospitals are to be expanded and will receive sums approximately as follows: Evangelical Deaconess, $290,000; Fairview Park, $250,000; Lutheran, $100,000; Grace Evangelical, $100,000; Huron Road, $350,000; Mount Sinai, $600,000; St. Alexis, $800,000; St. Ann's, $300,000; St. John's, $500,000; St. Vincent's, $900,000; University, $400,000; Woman's, $400,000, and Polyclinic, $100,000.

$120,000,000 Building Program

Dr. Frederick MacCurdy, New York state commissioner of mental hygiene, has filed plans for a $120,000,000 mental disease hospital construction program with the state postwar planning commission. He reports that the patients in state hospitals increased from 38,294 in 1920 to 83,053 in 1942.

AWARDS AND HONORS

Blewett, Evelyn: Received emblem and citation, August 14, for Meritorious Civilian Service to the War Department in "coordinating Army Nurse Corps procurement publicity activities of the Surgeon General's office with those of eight separate agencies vitally interested in the procurement program."

Dunham, Maj. Gen. George C.: Decorated with Distinguished Service Medal, August 9, "for performing exceptionally meritorious service in a position of great responsibility from 31 January 1942 to 8 June 1945." General Dunham, known as the "flying doctor of the Americas," directs more than 1000 health centers, disease control projects, medical and nutritional surveys from Chile to the Central American republics.

Fischelis, Dr. Robert P.: Received degree of Doctor of Science, honoris causa, July 24, from Philadelphia College of Science and Pharmacy. Doctor Fischelis' work with the War Production Board and as secretary of the American Pharmaceutical Association was cited.

Fleming, Sir Alexander: Received a silver plaque, a certificate and an honorarium of $1000, July 25, as the man whose humanitarian efforts contributed most to the welfare of mankind in 1944. The discoverer of penicillin was the sixth person and the first Briton to be honored by the Variety Clubs of America, a charitable organization of show business.

Hillman, Brig. Gen. Charles C.: Received the Legion of Merit for setting up physical standards for the war-time Army and for professional direction of the blood plasma program. He is chief of professional service, Office of the Surgeon General.

Jones, Col. Harold W.: Received honorary degree of Doctor of Laws from Western Reserve University, July 13, in recognition of his work in developing the Army Medical Library.

Rogers, Brig. Gen. John A.: Awarded Distinguished Service Medal by the War Department for his keen professional ability and tireless devotion to duty while he was First Army surgeon in France, Belgium and Germany from June 1944 to April 1945.

Tynes, Col. Achilles L.: Awarded Legion of Merit for planning standards for entire fleet of 29 Army hospital ships and for hospital facilities on troop ships. Colonel Tynes is chief of the hospital construction branch, Hospital Division, Office of the Surgeon General.

Evacuation Hospital No. 2 (St. Luke's, New York Unit): Award of Meritorious Service Plaque for "superior execution of duty in the performance of exceptionally difficult tasks . . . in every duty assigned to it." On D-Day plus two, Colonel William F. MacFee, director of surgery, crossed to the continent, followed shortly by the entire unit, which served in France, Belgium and Germany following closely behind front fighting lines. During this period some 20,000 wounded men were cared for.

20th General Hospital: Cited as a "living force" for superior achievements accomplished by the hospital personnel in the India-Burma theater in spite of many difficulties.

261st Medical Battalion: Cited for courageous performance of duty under exceptionally difficult and hazardous conditions from 6 June to 18 July 1944. In close support of assault troops on D-Day in Normandy, this unit handled more than 75 per cent of all casualties sustained on First Army beaches during the first ten days of the invasion. Officers and men worked day and night with no sleep whatever under enemy artillery fire and air raids, their operating tents constantly pierced by flak.

U.S.S. Solace, Naval Hospital at Pearl Harbor and Naval Mobile Hospital Unit No. 2: Awarded Navy Unit Commendation for extremely meritorious service during the attack on Pearl Harbor, Dec. 7, 1941.

Army Returns Paris Hospitals

The return to France of thirteen 1000 bed hospitals and 15,000 hotel rooms, requisitioned in the Paris area since last September, has been begun by the U. S. Army. Rent will be settled through reverse lend-lease.

California Hospitals to Benefit From Tax Exemption Bill

A saving of about $500,000 annually to nonprofit, charitable hospitals of the state of California is estimated by the Association of California Hospitals as a result of the passage by the recent legislature of a tax exemption measure. This bill will not be effective until 1946.

Many other important bills affecting hospitals were considered and some of them passed. Among the latter were a bill to license hospitals, a bill to require hospitals to provide emergency care to injured persons and to provide for payment for such care, a bill authorizing county hospitals to pay membership fees in hospital associations and two bills to set up committees to study prepaid health services.

None of the 12 bills on compulsory health insurance was passed although one of them was defeated in the assembly by only a few votes. It is now expected that Gov. Earl Warren may call a special session of the legislature in about six months to consider compulsory and voluntary health insurance.

One bill passed by the legislature authorizes local municipalities to adopt a system of group life, health and accident insurance and health services and to make wage deductions for the premiums.

Another bill signed by the governor permits osteopaths and chiropractors to furnish care under Workmen's Compensation. A bill was passed authorizing all counties with populations of less than 200,000 persons to form hospital districts with authority to build and operate hospitals and to issue bonds and levy taxes for such purposes.

Important improvements in mental hygiene legislation in California were outlined in this magazine last month.

Chicago Hospitals Issue Press Relations Code

A new code of relationship between hospitals and the press has been developed by the Chicago Hospital Council and the local newspapers. Under terms of this code hospitals may not release information regarding a patient to the press or permit photographers to take pictures of patients without the written consent of the patient and the attending doctor.

Newspapers are not to use the doctor's name without his consent. The hospital will not confirm the presence of public figures without their consent. Where there is widespread interest, a physician can arrange for periodic bulletins on the patient's condition.

Because of health department rules, pictures of new-born babies can only be taken through a viewing window. For police cases the information available from police records is automatically to be made available by the hospitals. Special precautions must be taken in cases of suicides, intoxication, drug addiction, or moral turpitude to avert the danger of damage suits. The death of a patient is presumed to be public property.

Three States Near End of Hospital Survey

In a cleanup drive in Michigan to obtain the last of the hospital schedules for the statewide hospital survey. Dortha Jenkins of Hillsdale, Mich., who was more recently employed by the Hospital Service Plan Commission, has been detailed to tour the state to obtain the remaining 65 schedules. It is hoped that all schedules will be in by September 15 and all tabulations for the state finished shortly thereafter.

Wyoming hospital leaders expect to finish obtaining their schedules shortly, as do those of Iowa.

A committee of 49 leaders to advise on the hospital survey in Illinois has been appointed by Governor Green. The committee held its first meeting in Chicago on August 20.

Rhode Island Blue Cross Enrolls 41 Per Cent of State Population

The Rhode Island Blue Cross plan announced on August 6 that it had enrolled 41 per cent of the people of the state before it celebrated its sixth anniversary. Nearly 60 per cent of the employes of the state government are members with pay-roll deduction privileges. The new comprehensive contract was credited by G. M. Congdon, president, with being "a potent factor in the steady growth."

Twelve Woonsocket textile firms are paying the cost of Blue Cross membership for each employed worker. These firms have more than 4000 employes. The Rhode Island plan is also preparing another direct enrollment campaign for the unemployed, self-employed, retired or otherwise disqualified persons under 65 years of age.

The new comprehensive plan offers up to 150 days of hospital care annually. This plan was introduced on a trial basis several months ago. Experience has been so satisfactory and management and labor have been so enthusiastic that it was decided on July 30 to make the plan available to all firms employing 25 or more people if 90 per cent of the employes are enrolled. Some firms are paying for both employe and dependent coverage, while the majority are paying for the employe only.

Provisions of the Rhode Island comprehensive plan are: up to 150 days of hospitalization each year but not more than 75 days for the same cause; room accommodations, meals and general nursing up to $6 per day, and the following benefits in member hospitals regardless of cost: operating room, all ordinary medicines including penicillin, surgical dressings, all laboratory examinations, basal metabolism tests, oxygen and serums and physical therapy. There are no physical examinations, no age limits and no waiting period for maternity benefits. Dependents are entitled to the same protection as the subscribers.

Issue "Story of Blue Cross"

"The Story of Blue Cross on the Road to Better Health" is the title of Public Affairs Pamphlet No. 101, issued during August and written by Louis H. Pink, president of the Associated Hospital Service of New York. The bulletin, which is extensively illustrated, discusses the origin of Blue Cross, how fast it has grown, problems of enrollment, the services provided, the control, the relationship to hospitals, state supervision, cooperation with medical plans, preventive medicine, the need for a comprehensive health plan and a health program in the U.S.A.

Reorganize Personnel Divisions of Bureau of Medicine and Surgery

WASHINGTON, D. C.—A recent functional reorganization of the personnel division of the Bureau of Medicine and Surgery, Navy Department, places the formerly separate personnel branches of the medical corps, nurse corps and hospital corps under one personnel division, an official of the Bureau of Medicine and Surgery said July 31. A complement planning and control branch and a training branch have been set up also.

The complement planning and control branch makes a study of military personnel needs and plans, recommends, coordinates and controls military personnel complements and allowances for the medical department.

The medical corps branch establishes qualification standards for and classifies professional specialties of medical officers. It passes upon candidates for commissions and makes recommendations for assignments, promotions and transfers of medical officers. The medical corps maintains personnel records as well.

The nurse corps establishes qualification standards for naval nurses and classifies their specialties. It selects and recommends candidates for commissioning in the Navy Nurse Corps. It makes recommendations for assignments, promotions, transfers and special separation requests of naval nurses. This corps also maintains personnel records and prepares personnel documents on naval nurses.

The hospital corps prepares curriculums for training courses in hospital corps schools and recommends quotas for them. It has cognizance similar to the other branches in such matters as assignments, promotions and transfers of officers of the corps and it maintains records on all active and inactive personnel of the hospital corps.

Among duties of the training branch is handling such programs as internship and resident training, hospital training, hospital corps training, nurse corps indoctrination and correspondence courses. It also plans, prepares and distributes training aids.

Maternal Mortality Down in 1940-1943

The most startling reduction of maternal mortality probably ever recorded occurred during the period from 1940 to 1943 when the rate in the United States fell by more than one third to a level of 21 maternal deaths per 10,000 live births for the white population and 51 per 10,000 for the colored. These figures were revealed by the *Statistical Bulletin* of the Metropolitan Life Insurance Company for July 1945.

The most rapid improvement during these three years was in the areas that previously had the poorest records—the South and the Mountain States. These areas, where the rates still continue relatively high, also have the smallest proportion of their births occurring in hospitals.

The percentage of births in hospitals ranged from a low for whites of 42.8 in the East South Central States to a high of 94.8 in the Pacific States. For Negroes the percentages were 12.1 in the East South Central States and 87.7 in the New England States.

Urges Need for Health Centers

Unusual in the annals of hospitals was the recent publication by Manitoba Pool Elevators, Winnipeg, Man., of a booklet describing the need for hospitals and health centers, for prepaid hospital and medical service and for the coordination of hospital care on a province-wide basis. It is entitled "The Rural Health Centre—A Living Memorial." The provincial department of health and public welfare cooperated with the Manitoba Pool Elevators in preparing the material.

Kaiser Suggests Bill to Guarantee Loans for Group Medical Practice

WASHINGTON, D. C.—A bill to empower the Federal Housing Agency to guarantee 90 per cent of local bank loans to build and equip hospitals for groups of doctors that undertake to provide prepaid medical care has been drafted by Henry J. Kaiser for submission to the Pepper subcommittee on war-time health and education. Officials of the Pepper committee, however, were vague and evasive about the bill when questioned.

"Under the bill," Mr. Kaiser declared in a newspaper column of August 20, "doctors interested in group practice could invest the funds set up for them by the G.I. Bill of Rights in their own group practice clinics at home. Together, 10 of them could make up a pool of $25,000 and get a loan of $250,000 to set up much-needed medical facilities. I can see little Mayo Clinics springing up all over the nation. Founded on the sound economics of prepaid medicine, these clinics would operate as going business enterprises, competing to reduce their cost, improve the quality and expand the scope of their service to the public."

Chicago Hospital Lists Rules Governing Memorial Rooms, Beds

Regulations governing the naming of memorial beds and rooms at St. Luke's Hospital in Chicago have been adopted by the board of trustees at a meeting held recently. All funds given for such designations are made a part of the hospital's endowment. The regulations are as follows:

1. For $5000 a bed in a ward will be named in perpetuity but without right in the donor to designate an occupant.
2. For $7500 a bed in a ward will be named in perpetuity and during life the donor shall have the right to designate the occupant of the bed, provided that in any one calendar year the total amount of free service so designated shall not exceed $200.
3. For $10,000 a private room will be named in perpetuity but without right in the donor to designate an occupant.
4. For $15,000 a private room will be named in perpetuity and during life the donor shall have the right to designate the occupant, provided that in any one calendar year the total amount of free service so designated shall not exceed $400.
5. It is understood that any donor, exercising the right to designate the occupant of a bed or room, shall only designate one patient at a time. Should the bed or room be occupied, the person designated by the donor shall have preference over other applicants when a vacancy occurs.
6. Persons designated to occupy beds or rooms must be worthy of free service and must be persons whose financial resources do not permit payment for services from their own funds.
7. In the event that a memorial bed or room is located in a portion of the hospital property which, with the passage of time or hospital alteration, may no longer be available, suitable recognition of the gift shall be made in some other manner.

Scholarship Fund Granted

A $12,500 grant for scholarships from the American Hospital Supply Corporation to cover tuitions of selected students in hospital administration has been announced by Dr. Malcolm T. MacEachern, director of the program in hospital administration at Northwestern University and associate director of the American College of Surgeons. The grant will be payable in five annual installments of $2500 beginning this year. The American Hospital Supply Corporation gave $5000 for scholarships when the program in hospital administration was started in September 1943.

Baruch Committee Achieves Results "Beyond Expectations"

The year 1944 will go down in the history of physical medicine as one of the great strides towards its long-delayed expansion, according to a release from the Baruch Committee on Physical Medicine. In a survey of 124 medical centers, 88 reported to the committee significant advances in physical medicine's development which 75 attributed directly to the activities of the Baruch Committee.

In addition to its grants for research and fellowships, the committee seeks to bring the need and value of physical medicine to the knowledge of the public and to provide advice and guidance.

One project that has won widespread public support is to build soldiers' memorials in the form of permanent establishments for the restoration of injured veterans rather than stone or bronze monuments. A blueprint of such an ideal war memorial has just been sent out. This would help to avert one of the tragic conditions following the first World War, the committee says, "the segregation of disabled fighting men into large veterans' hospitals remote from their homes. In those institutions the personal outlook of many of the men was permanently hopeless and they passed their days in a state of mental apathy, disillusion and, in many cases, bitter resentment."

Under the Baruch Committee plan, returned veterans would be placed in centers close to their homes. Presumably, these centers would or could be associated with existing hospitals.

Canada Surveys National Health

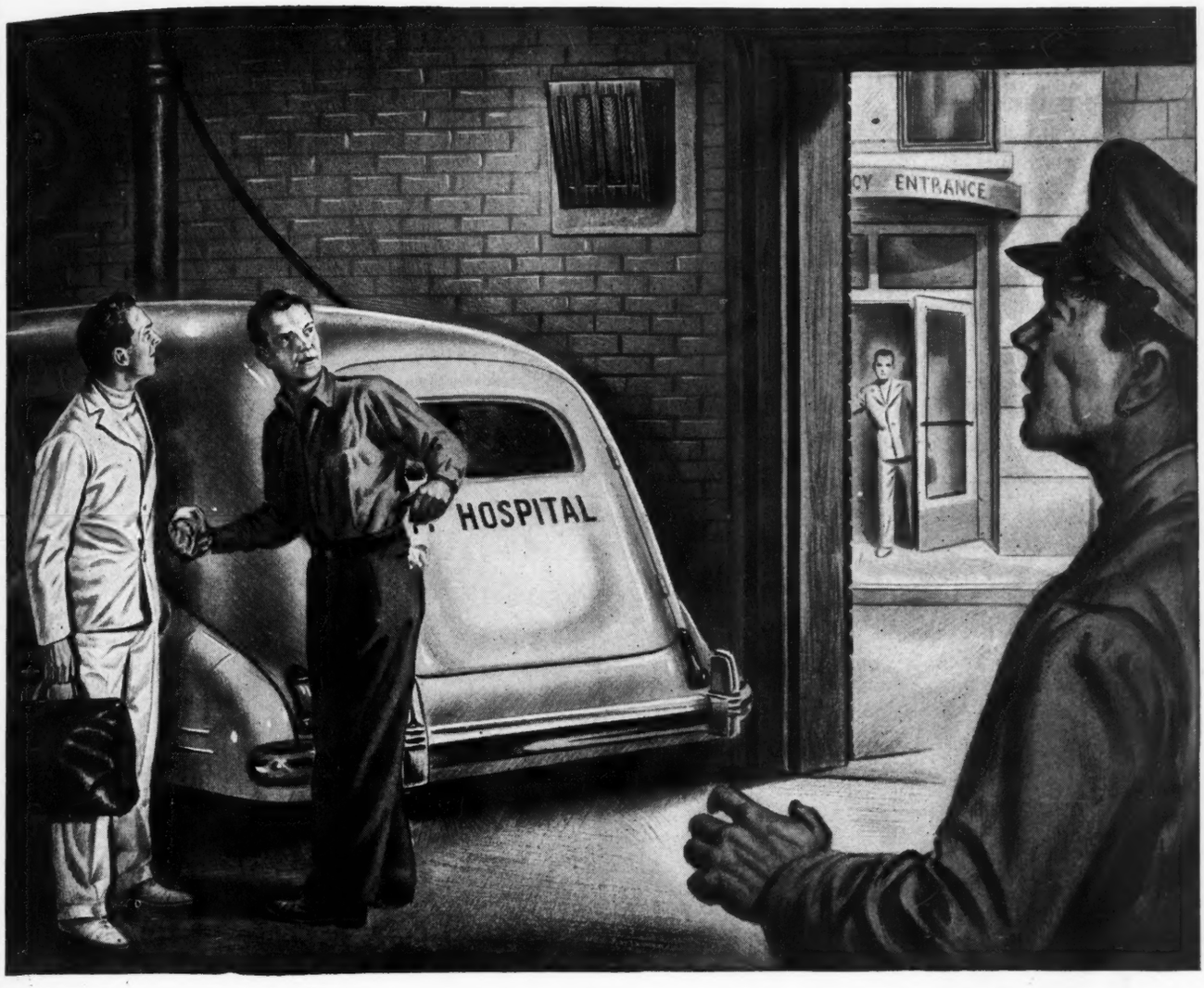
With the war over, facilities should be made available for the better training of hospital administrators, nurse supervisors and instructors, laboratory technicians, radiological technicians, dietitians, medical records librarians, social service workers, nurses serving as clinical assistants, hospital accountants, hospital purchasing agents, ward aides, orderlies and technicians in Canada, according to a National Health Survey of Canada conducted by the Canadian Medical Procurement and Assignment Board. The various professional bodies in Canada cooperated in the study.

Civilian hospital accommodation should be increased to meet the increasing civilian demand and some of the military hospitals erected should be close to civilian hospitals so that they can be used as wings of civilian hospitals when they no longer are needed for military patients, the report states. Voluntary organizations and religious bodies should be given municipal and provincial aid in order to meet the needs for additional civilian hospitals but where voluntary bodies do not take the lead in providing certain types of accommodation the municipality and the province should provide the necessary institutions.

The report recommends a commission on hospitalization in each province representing the public, the hospitals and the government to work out a long-range program of hospital construction and interrelationship.

Hospital Urged as Memorial

An Australian memorial to the late President Roosevelt will be erected by the Commonwealth Government and H. P. Boulter, the editor of the *Hospital Magazine,* has suggested that it should take the form of a hospital. In presenting his suggestion the editor stated that "certainly Australia, of all places outside the United States of America, should have a memorial to this great man who, in collaboration with Winston Churchill, prepared for the day when American forces would have to fight this war and defend our country in the course of the mutual help strategy. They came; they saw; they helped to conquer and Australia has reason for gratitude."



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Medical Service Plans Report Record-Breaking Enrollment Increases

Growth of the 25 medical and surgical plans which are now coordinated with Blue Cross plans was greater during the first six months of 1945 than for the entire year of 1944, James F. Cowan, Jr. field director of the Hospital Service Plan Commission reported on August 3. The 146,785 new members enrolled during this six months is more than double the increase for the corresponding period of 1944.

Michigan Medical Service with 842,057 members and with a gain of 68,000 members between April 1 and July 1 continues to be the largest plan and the one with the largest net growth.

The total number of persons covered by the 25 plans increased from 1,580,000 on April 1 to 1,825,000 on July 1. Plans showing a growth of 10,000 or more for the quarter are: California Physicians' Service (10,000), Colorado Medical Service (16,000), Group Hospital Service of Delaware (13,000), Massachusetts Medical Service (39,000), Michigan Medical Service (68,000), United Medical Service of New York City (31,000), Hospital Saving Association of North Carolina (13,000) and Medical Service, Inc. of Charleston, W. Va. (14,000).

So far this year six new plans with headquarters in New Orleans, St. Louis, Syracuse, Tulsa, Cleveland and Dallas have started enrollment. Several others are in process of organization.

Set Up Standards for Tuberculosis Hospitals

A set of minimal medical and administrative standards for tuberculosis hospitals and sanatoriums was published in booklet form during August by the American Trudeau Society, based on a report of its committee on sanatorium standards. Dr. Ralph Horton is chairman of the committee.

"The medical superintendent, an appointee of the governing board, should be responsible solely to the board for the management of the institution and for the medical care and treatment of all patients," declares the report. "All officers and employes should be appointed by him or subject to his approval and be answerable to him."

Other standards concern the medical staff, medical services, the care of children, routine laboratory procedures, nursing service, health supervision of nurses and other employes, special services and salaries.

For salaries the committee suggests $5000 to $6000 for the medical superintendent of a hospital of 100 beds or less and $6000 to $8500 for hospitals of 200 beds or more. Pathologists', roentgenologists' and senior resident physicians' or surgeons' salaries are listed at $4000 to $5000 (whether full-time or part-time is not specified). Superintendents of nurses should be paid $2000 to $2500 in the smaller and $2500 to $3000 in the larger institutions. Graduate nurses are listed at $1400 to $1800 and undergraduate nurses or nursing attendants at $900 to $1200. All salaries are in addition to maintenance.

Deaconess Hospital Expands

A million dollar building improvement program for the Protestant Deaconess Hospital, Evansville, Ind., was started on August 1. The expansion project will include wards and private rooms for Negroes, a new clinical building, central power and heating plant and laundry, an isolation unit for communicable diseases, new ambulance entrance, first-aid and emergency rooms, administrative offices, pharmacy, enlargement and modernization of the surgery, complete remodeling of the present hospital buildings and chapel. In addition to the clinical facilities the new building program will also add 125 beds to the present capacity.

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Hershey Report Urges Expansion of Psychiatric Training

An expansion of psychiatric training of picked medical personnel in military installations is urgently desirable, according to a report of the Hershey conference on psychiatric rehabilitation published in August.

Other recommendations of this conference include the provision of more facilities other than hospital care, impartial restudy of the facilities and policies of the Veterans Administration, intensified public education efforts by the National Committee for Mental Hygiene, education of general practitioners on the neuroses and their care and fellowships for training internists in psychiatry.

The conference recommended comprehensive medical care and teaching to both undergraduates and house officers, with psychiatrists and internists jointly carrying the major teaching responsibility.

Reciprocal arrangements between the American Boards of Internal Medicine and Pediatrics and the American Board of Psychiatry and Neurology were recommended whereby the former would give credit for a limited amount of experience in psychiatry while the latter would give credit for a limited amount of experience in internal medicine or pediatrics.

Vinson Report Urges Better Medical Care

A strong plea for the provision of better medical care, the institution of more adequate grants-in-aid to the states for hospitals and health centers and better equalization of educational opportunities was made by Fred M. Vinson in his last report as director of the Office of War Mobilization and Reconversion before accepting his new duties as Secretary of the Treasury.

"Unless we take proper measures to give every child the right start in life—through education and adequate medical facilities — we are guilty of wanton waste," he said. "Unless we guard the grown individual against the full shock of the inevitable dislocations of our highly mechanized civilization, we are unnecessarily callous."

While urging the states to play their part in such protection, he said that concerted action takes time and it is "not too early to consider the general structure of a more adequate social security system."

Indiana Council Organized

The Indiana Council of State Organizations, with Judge Wilfred Bradshaw of Indianapolis as chairman, has been organized to bring together statewide organizations, agencies and departments interested in welfare, health, education and safety, to facilitate an exchange of ideas and to encourage joint effort and planning in these fields. Through bulletins and other mediums, members will be kept informed as to the developments and trends in their fields of interest, as well as those of related fields. The council will issue and maintain a directory of Indiana organizations, including a statement as to the purpose and functions of these organizations. The Indiana Hospital Association is a charter member of the group.

U. of C. Plans Memorial

The University of Chicago is considering plans for the erection of a million dollar permanent memorial to Mr. and Mrs. William J. Chalmers to replace the Country Home for Convalescent Children at Prince Crossing, near Wheaton, Ill., which was sold recently to Wheaton College. The memorial will form part of the university's integrated medical center and will house the plaques in the various Prince Crossing buildings indicating their donors.

Army Discloses Redeployment Program for Nurse Corps

WASHINGTON, D. C.—Marital status, age and physical condition, as well as number of points, will be taken into consideration by the Army in redeploying nurses from the European theater, according to the *Army and Navy Journal* of August 11. The redeployment program, it was emphasized by Lt. Col. Ida W. Danielson, theater chief nurse, is designed to shift, not to discharge, nurse personnel and "nurse strength will only be decreased here in proportion to the gradual decrease of troop strength."

Under the new program, preference for assignments to duty in the United States will be given to married nurses whose husbands have been returned from an overseas theater and those with scores above 70 points. Priority will go to those with the highest scores.

Unmarried nurses with intermediate scores—between 55 and 70 points—will be placed in Army of Occupation hospitals or possibly redeployed to the Pacific through the United States.

Unmarried nurses with low scores—fewer than 55 points—may be redeployed directly to the Pacific or be placed in Occupation hospitals.

Nurses who wish to be discharged should initiate a request "through channels" addressed to the Adjutant General, War Department.

Hospital Industries Back Physicians' Group

A hospital industries committee of the National Physicians' Committee for the Extension of Medical Service has been appointed under the chairmanship of Howard M. Fish and has "registered full approval of the activities of this committee," has pledged the financial support of the individual firms and recommended to all members of the Hospital Industries Association and to business and industrial leaders generally "that they give voluntary moral and financial support to this uniquely effective agency."

In Washington, President Truman expressed on August 20 to Senators Murray and Wagner his full support of the Wagner-Murray-Dingell Bill.

Postwar Jobs for Nurses

To help in the recruitment of public health nurses after the war and to guide nurse veterans of this war, the National Organization for Public Health Nursing has prepared a leaflet, "Your Postwar Job," which explains preparation, hours, salaries and opportunities for returning nurses.

Benjamin Franklin launched a kite with a pointed wire fixed to the end in an attempt to draw lightning down the kite string to an iron key tied to the end of it, thus proving that lightning and the strange force which scientists were just beginning to call electricity were the same.

Two Hospitals Report on the Year's Activities

A handsome report for its forty-ninth year was published in August by Moline Public Hospital, Moline, Ill. The report follows modern trends with many illustrations and pictorial statistics and relatively brief written reports. The front cover with a striking picture of the hospital's front door bears the legend: "Twenty-four hours each day . . . twelve months of the year . . . constant traffic through these doors bears witness that the circle of human kindness still cares for the sick."

The 173rd annual report of the Society of the New York Hospital, also issued in August, covers 1944. "Older than the republic, the New York Hospital was chartered in 1771 by King George III," says the opening sentence. During its history the hospital has cared for 3,203,000 patients.

A.P.H.A. Accrediting Program

A new accrediting program for schools of public health was announced on August 27 by the American Public Health Association. The association's committee on professional education will undertake the program, which will be of interest to hospital administrators because of the greatly increased emphasis on public health aspects. Professor C.-E. A. Winslow of New Haven, Conn., will be the counselor in charge of the investigative work.

Michigan, South Carolina Offer Health Programs

A five point program entitled "Better Health for the American People" has been published by the Michigan Health Council, a group representing the state medical and hospital associations, and the medical and hospital prepayment organizations.

The program calls for: (1) complete health prepayment service for the self-supporting; (2) cooperation with government to furnish health care for those unable to pay; (3) improvement of health facilities and standards; (4) health education of the public, and (5) national coordination of health activities.

In connection with prepayment service, the council recommends the addition of further services as rapidly as the public demands them, extensions to individuals and to farmers and complete elimination of exclusions.

As for health facilities, the council recommends wider geographic distribution, quantitative and qualitative adequacy and the integration of health activities. It invites other professional groups, such as dentists, nurses, public health officers and pharmacists to join it. There is no mention of group practice or of consumer representatives.

It asks all other states to set up similar health councils to be federated in a national health congress at the earliest possible time.

The South Carolina Medical Association also recently published a 10 point program. These points were: (1) to establish closer cooperation among the groups and individuals concerned; (2) to prevent political control; (3) to study the need and availability of medical care in each county and the effectiveness of present work, and to promote plans for improving medical care where there is need; (4) to finance hospital care of the indigent by public county funds and promote clinics in each county for indigents also financed by county tax funds; (5) to make voluntary hospital insurance available to all the people of the state and to promote the widespread purchase of such insurance; (6) to study hospitals of the state and approve those that meet acceptable standards; (7) to establish group health insurance plans in all industries; (8) to approve insurance companies that sell medical or hospital insurance of acceptable standards; (9) to promote better medical and nursing education, and (10) to educate the public regarding present facilities.

Navy Will Transfer Psychotic Cases From St. Elizabeth's Hospital

WASHINGTON, D. C.—In compliance with the President's recent directive that the Navy Department withdraw its psychotic patients from St. Elizabeths' Hospital and assign no new ones there, the Bureau of Medicine and Surgery is studying ways and means of transferring such patients, an official of the Bureau said July 30. Naval hospitals are at present being surveyed in order to determine the most advantageous placing of these patients.

The directive was initiated by Budget Director Harold D. Smith who declared that some reasonable limit must be set on the size of the hospital. As of June 30 this year there were 7466 patients at St. Elizabeth's, a population growth of more than 239 per cent over the 2199 patients there in 1935. The increase occurred since the beginning of the war and represents patients from the Navy.

St. Elizabeth's was founded for the treatment of the mentally ill of the Army and Navy of the United States and the District of Columbia. Army psychotic patients are now treated in Army hospitals and the Veterans Administration takes care of such patients in veterans' hospitals.

OFFICIAL ORDERS
July 15 to August 18

Ambulances.—Hearses and ambulances were removed from rationing on August 3.

Construction Materials.—Two regulations providing manufacturers' ceiling prices for these materials and specified mechanical building equipment were announced by O.P.A. on July 23. Ceiling prices are the same as they were under M.P.R. 188 for those items formerly covered by the latter order.

Crude Drugs—Price control will no longer be exercised for crude botanical drugs imported from Canada, laboratory reagent specialty solutions and prepared culture media, O.P.A. announced on July 27.

Fabrics.—Schedule B of L-99 was revoked by W.P.B. on August 18 to permit manufacturers to produce bedspreads, upholstery fabrics, draperies and similar items instead of Army tents.

Gauze.—A maximum price of eight cents per square yard for chemically treated gauze purchased from the Department of Commerce's Office of Surplus Property or any other government agency was established July 30 by O.P.A. This maximum price applies to sales by all resellers in any quantity and to any class of purchaser. The gauze cannot be sold for the uses indicated on the label. It must be removed from the original package, rewrapped and sold for uses other than medical, cosmetic and hygienic. The gauze may be used for such things as dust cloths and cleaning cloths.

Meat.—Indefinite suspension of the government setaside orders on beef, veal and hams was announced on August 20 by Secretary of Agriculture Anderson. Pork loins, shoulders and lard remain under set-aside orders.

Milk.—Sales quotas for milk, cream and buttermilk were suspended by Secretary of Agriculture Anderson on August 1.

Quinine.—A limited amount of quinine is being released from government stockpiles for civilian anti-malarial and other essential medicinal needs, W.P.B. announced on August 11.

Surplus War Goods.—To prevent excessive charges for these goods, O.P.A. announced new pricing provisions on July 23.

Dewey Orders New York Survey

The health commissioner, mental hygiene commissioner and social welfare commissioner of the state of New York have been appointed by Governor Dewey as a joint hospital board to formulate and carry out hospital construction plans. The governor designated the state post-war public works commission to survey the state's hospital needs. Assemblyman Lee B. Mailler, superintendent of Cornwall Hospital, Cornwall, N. Y., was named adviser to the hospital board. The board will also appoint an advisory council.

Free Care for Tuberculous

Free care for all tuberculous persons who have legal residence in Wisconsin, regardless of ability to pay, is provided under legislation passed by the recent session of the state legislature. However, any patient who desires to pay for any part of the cost is permitted to do so. Illinois, New York, Arkansas and Oklahoma are reported to be other states with similar laws.

Medical Records School to Be Opened by N. U. and Wesley Hospital

Wesley Memorial Hospital in affiliation with Northwestern University, Chicago, will open a school for medical records librarians on September 25. Students who successfully complete the twelve months' course will earn 24 semester hours of credit toward a bachelor's degree. The director of the school will be Mrs. Edna K. Huffman, medical records librarian of Wesley Hospital. Mrs. Huffman has previously started two other similar schools in Chicago, at Grant Hospital and at St. Joseph's Hospital.

This new school will be the eleventh one in the United States approved by the American Medical Association. These schools are not graduating enough trained librarians to meet normal requirements and do not begin to meet the needs of increasing hospital facilities, according to an announcement from Wesley.

A minimum of 60 semester hour credits from an accredited college or university is a prerequisite for entrance. Proficiency in shorthand and typing is also essential. Applicants for admission to the school should be between 20 and 35 years of age.

Booklet on Medical Careers

A booklet entitled "Facts About Your Medical Career on Demobilization" has been published by the Minister of the Department of Veterans Affairs, Canada, based on a compilation by the Canadian Medical Procurement and Assignment Board. This booklet lists all of the refresher courses and postgraduate training opportunities available in Canada, and gives general information for the benefit of physicians. Among other possibilities suggested is postgraduate training in hospital administration. The booklet reports that "a number of the larger Canadian hospitals will provide openings for a medical administrative intern for periods of a few months to a year of practical experience but the list of hospitals affording such an opportunity is not yet completed."

New Jersey Hospital Expands

Expansion plans for the New Jersey Orthopaedic Hospital, Orange, N. J., include a new building providing 20 additional beds with added facilities for private patients, enlarged clinics and service quarters. The total amount will represent approximately $300,000. Mrs. Grace C. Oakley, New York City, has been retained as consultant to the hospital's department of appeals.

New Survey Bill Introduced

WASHINGTON, D. C. — Still another hospital survey bill was introduced July 18 in the House. It is identical with those that preceded it.

Senator Hill of Alabama introduced for himself and Senator Burton the first of these hospital construction bills (S. 191) early in January. S. 191 and those that followed envisaged a broad-gauged program for federal grants-in-aid to the states to assist the construction of necessary hospital and public health facilities. The most recent bill was introduced by Mr. Snyder and referred to the Committee on Interstate and Foreign Commerce.

N. Y. Agencies Name Committee

An advisory committee of not less than five members including the president and executive secretary of the New York State Hospital Association will be named to confer with the state departments of health, education and social welfare as a result of discussion between the state hospital association and officials of these departments. The mutual interests of the three departments will touch such matters as standards and quality of hospital services, strategic location of hospital services and an equitable and uniform system of calculating daily rates for care.

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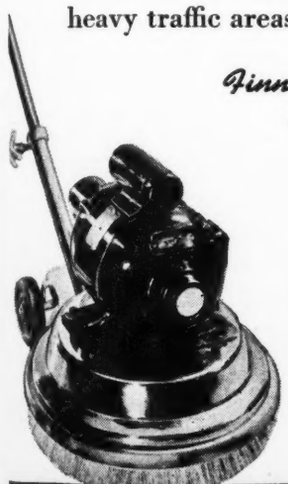

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Yakima Plan Successful

Although in Washington the state Blue Cross organization and the local county medical bureaus have been fighting each other a combined plan in Yakima is proving to be a "huge success" after two months' operation, according to the *Washington State Blue Cross News.*

"The plan was instituted two months ago after Yakima business men, doctors and Blue Cross officials made an exhaustive study of the need for this type of coverage," the report says. "A joint contract was drawn and an extended sales campaign to acquaint the public with benefits to be derived from such a plan was begun."

Anniversary Report Issued

A handsome fiftieth anniversary report was issued by Mercer Hospital of Trenton, N. J., during August. The report contains 76 pages plus a fold-in center spread giving a panorama of the hospital as it is today. Sections of the report deal with the general history of the hospital, the history of the medical staff, nursing department, women's aid association, volunteer aides, U. S. Army Ambulance Corps and various departments. Names of incorporators, officers and directors since the hospital's organization are included. A similar list covers officers of the medical board and graduates of the school of nursing.

Doctor-Patient Ratio to Be One to 733, Rappleye Report States

Reliable actuarial studies by Selective Service headquarters and other authorities indicate that the present production of physicians will ensure one doctor to every 733 people in the United States in 1950, according to Dr. Willard C. Rappleye, dean of the Faculty of Medicine of Columbia University.

This ratio is "twice as many physicians per unit of population of any country in the world previous to the war and well above the ratio generally accepted as sufficient for good medical care," Doctor Rappleye stated.

In his article he pointed out that much has been said recently about deferring high school boys to enter premedical education but that they would not be available with even minimum preparation until the fall of 1947. "It is fully expected that by that time there will have been discharged large numbers of servicemen who desire and should be given the opportunity, if qualified, to pursue professional training."

Seek to Expand Hospital

WASHINGTON, D. C.—A bill was sponsored July 29 by Senator Radcliffe of Maryland authorizing use of $1,800,000 in federal funds for the expansion and reconditioning of the Columbia Hospital for Women, Washington, D. C. The bill, similar to one offered earlier in the House by Representative Norton, New Jersey, authorizes a maximum outlay of $1,300,000 through the community facilities funds of F.W.A. for remodeling and expansion of the main building of the hospital to provide an additional 145 beds. It authorizes $500,000 to replace the old cottages used as a nurses' home and school.

Newton Campaigns for Funds

A campaign is underway to raise $2,250,000 to enlarge the Newton-Wellesley Hospital of Newton, Mass., to 396 beds and to enlarge and modernize the school of nursing. In addition, the Founders' Memorial building is to be rehabilitated to serve as a modern outpatient department and private doctors' clinic. A modern psychiatric department will be included in the new program. Gerhard Hartman is director of the hospital; Dr. Claude W. Munger is consultant, and Coolidge, Shepley, Bulfinch and Abbott are architects.

ABOUT PEOPLE

(*Continued From Page* 88)

Mr. Yurchenco recently won second prize in the General Motors architectural competition.

Isadore Rosenfield has resigned as chief architect, in charge of hospital planning, of the city of New York, to establish his own office as architect and hospital consultant at 19 West Forty-Fourth Street, New York City.

Lt. Col. Hardy A. Kemp, secretary of the Army Medical School in Washington, D. C., and former dean of the college of medicine at Ohio State University, has been appointed dean of the Wayne University College of Medicine. He will assume his duties as soon as he is released from the Army.

F. E. Kassner, former administrator of Springfield City Hospital, Springfield, Ohio, has decided to reenter the public accounting field and has announced his association with Maxwell Abbell & Co., certified public accountants, Chicago.

George B. Colonna is the new chairman of the board of trustees of the Hampton Training School for Nurses, Inc., and Dixie Hospital, Hampton, Va.

James L. Fieser has resigned as vice chairman at large of the American Red Cross to become assistant to the president of the National Safety Council.

Capt. William E. Eaton, Medical Corps, U. S. Navy, has been relieved as head of the Washington office, Matériel Division, Bureau of Medicine and Surgery, to devote full time to his duties as head of the postwar planning board.

William Y. Elliott, vice chairman for civilian requirements, W.P.B., has resigned and will return to Harvard University as professor of government. **A. C. C. Hill Jr.,** deputy vice chairman, has succeeded him at W.P.B.

Willis E. Wright is the new librarian of the Army Medical Library, probably the best medical library in the world.

Josephine Nelson has been appointed director of public information for the National Nursing Council for War Service, succeeding **Florence M. Seder.** Miss Seder has joined the nursing information bureau of the American Nurses' Association. At the same time announcement was made of the selection of **Mrs. Hope Newell** as recruitment secretary of the council to replace **Mary L. Foster,** who has resigned to become assistant professor at Wayne University College of Nursing.

Maj. Robert G. Boyd, executive officer of the Inter-American Defense Board, has been promoted to the rank of lieutenant-colonel. Colonel Boyd was formerly head of Presbyterian Hospital, San Juan, P. R.

Deaths

Dr. Hugh Cabot, one of the progressive thinkers in medicine, died suddenly on July 15, at the age of 73. Doctor Cabot, former professor of surgery at Harvard and at the Mayo Clinic, was the author of many forward-looking books on medicine and nursing and was the winner of The MODERN HOSPITAL's gold medal award in 1943 with an article on "The Future of Nursing Education."

Dr. Joseph C. Regan, at one time medical superintendent of Kingston Avenue Hospital for Contagious Diseases, Brooklyn, N. Y., died at the age of 52.

Barbara Story Quin, who had been assistant director of the Commonwealth Fund since January 1922, died recently.

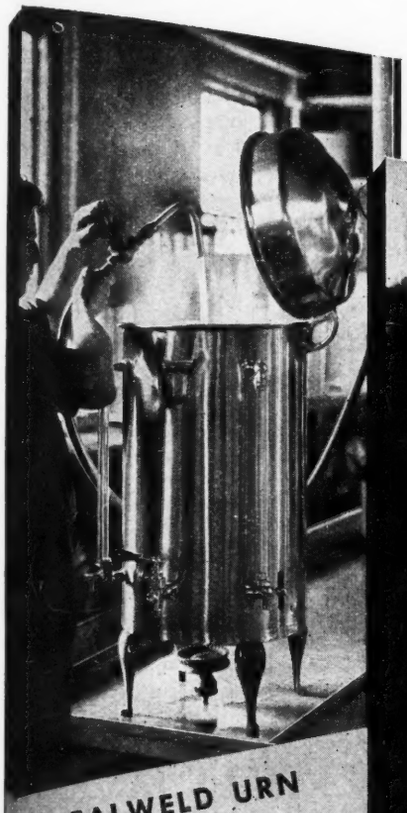
A. L. Bowen, 75, former director of the Illinois State Welfare Department, died recently at Elgin, Ill. Mr. Bowen entered the state service in 1909 as director of the state charities commission and became director of state institutions and the welfare department in 1929. He left his position in 1940.

Alderman W. Hyde, secretary of the Nuffield Provincial Hospitals Trust Fund until the end of 1943 when he became a governing trustee of the fund, died recently at his home in England.

8 hours AGAINST AN OPEN FLAME!

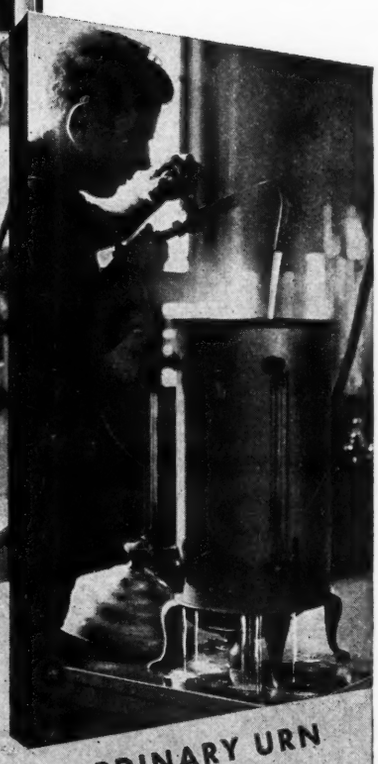
SEALWELD* *Burnout-proof* COFFEE URN

remains leak-proof after rigid test . . .



SEALWELD URN

● After 8 hours of exposure to open flame, the SEALWELD joints are still in perfect condition. The urn holds water without any evidence of a leak. Bottom is as strong as ever. SEALWELD construction protects you against forgetting to turn off the heat or to replace the water in the jacket.



ORDINARY URN

● After 5 minutes, the entire bottom has burned out because the solder in the bottom seam melted. Water leaks right through. Only SEALWELD construction protects you against burn-outs.

An exclusive BLICKMAN development, America's *first* burnout-proof urn, was put on the market only after intensive tests under severe conditions. Actual gas flame burner tests were made on both SEALWELD and ordinary urns. Each urn was tested without water in it, and the open flame played directly against the bottoms. The results are shown in the photographs at the left.

The SEALWELD burnout-proof coffee urn was undamaged — showed no sign of a leak. *But* with an ordinary urn (*in only five minutes* of the same treatment) the entire bottom burned out and water leaked through because the solder in the bottom seam melted. This can happen whenever someone forgets to turn off the heat or neglects to replace water in the jacket. The SEALWELD bottom suffered no damage because SEALWELD seams are *welded* into a continuous watertight seal — burn-out-proof. These urns are fabricated from stainless steel (now available for the civilian trade) are easy to clean, permanently bright, thoroughly sanitary. Write now for further details. . . . . **S. Blickman, Inc. 1509 Gregory Avenue, Weehawken, N. J.**

2-Piece Sealweld Battery in Stainless Steel

You Gain 5 Ways with Sealweld Urns

1. You'll never have a burnt-out or leaky bottom. Seams are welded leak-proof.
2. You'll save cleaning time — made of easy-to-clean polished stainless steel.
3. Your urn is permanently bright — there's no surface plating to wear off.
4. Your coffee flavor is protected by sanitary, corrosion-resistant surfaces.
5. You'll use it longer — make better coffee — keep your customers satisfied.

Send for "SEALWELD" catalog. Gives detailed specifications. Please write on your letterhead.

ARMY E NAVY

S. BLICKMAN, INC.

EST 1889

*Reg. U.S. Pat. Off.

EQUIPMENT FOR THE MASS PREPARATION AND SERVICE OF FOOD

Georgetown Launches Campaign

A campaign to raise $750,000 to build a new Georgetown University Hospital in Washington, D. C., has been launched, with James E. Colliflower as head of the general committee and Senator McMahon of Connecticut as chairman of the executive committee. The new hospital will cost approximately $2,570,000, with a grant of $1,820,000 allowed by the government if the remaining $750,000 is raised by subscription.

Syndicates Health Articles

Dr. William A. O'Brien of the University of Minnesota has begun a series of syndicated health articles in the Scripps-Howard newspapers under the title "The Doctor Says." Doctor O'Brien directs the medical and hospital courses at the Center for Continuation Study and has long been a prominent and active worker in the Minnesota Hospital Association, whose public relations program he directs. He has been giving radio programs for 17 years and is one of the most popular radio columnists in the Northwest.

Third Fund Campaign a Success

The third fund-raising campaign conducted by Buhl Hospital at Sharon, Pa., since 1940 has netted a total of $401,100 for modernization and an addition to the present plant. In the first appeal, $145,000 was raised for a new addition, and in 1942, $303,000 was raised, bringing the total of the three campaigns to $849,100. When the present building program is completed, the hospital will have 289 beds in comparison to its 124 beds in 1940.

Survey Nebraska Salaries

A study of salaries in 58 hospitals has been completed by Robert B. Witham, president of the Nebraska Hospital Assembly. This indicates the wide range in salaries paid by the hospitals. There were three superintendents receiving from $100 to $149 per month and, at the other extreme, were three receiving more than $450.

Plan Huge X-Ray Machine

The largest x-ray machine ever to be used in the treatment of cancer will be installed in the proposed new cancer clinic of The Veterans Administration Facility, Hines, Ill., according to Charles G. Beck, manager. The machine generates 2,000,000 volts, double that of the machine now in use at the hospital. Bids for construction of the new addition will be opened in September.

Study Nurse Salaries

A joint working committee of the Michigan State Nurses' Association and the Michigan Hospital Association was authorized at a meeting of the hospital group late in July. A tentative schedule of minimum salaries and personnel practices for institutional nurses was drawn up by the nurses' association and will be the subject for joint consideration. The schedule suggests a minimum entrance salary of $160 per month with increases of $2.50 a month every six months until $175 is reached. These figures are without maintenance.

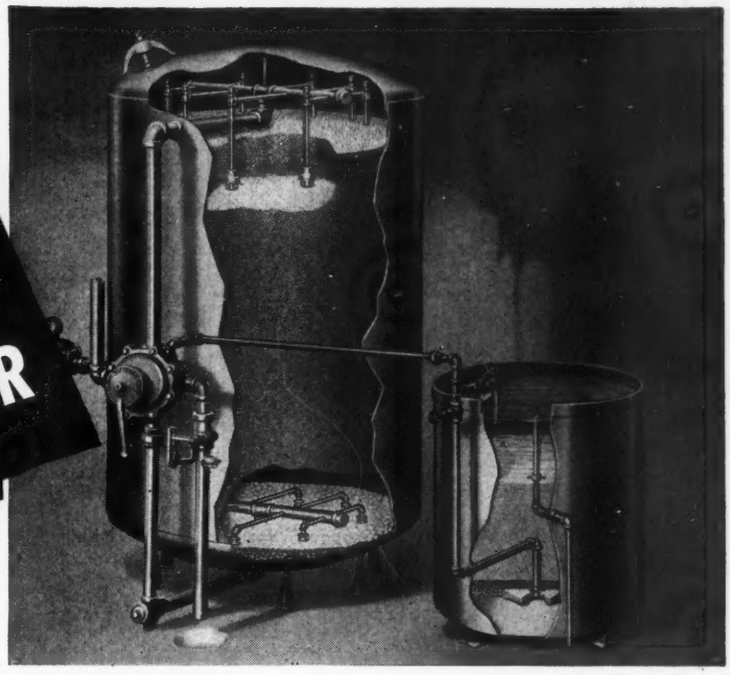
Tribute to Psychiatrists

WASHINGTON, D. C.—A commission of outstanding civilian psychiatrists expressed its admiration for the courage, ingenuity and accomplishments of its colleagues overseas after completing a eleven week survey of psychiatric conditions in the European Theater of Operations. Approximately 90 per cent of combat exhaustion cases are returned to duty largely as a result of prompt detection of symptoms and skilled handling of patients, the commission declared. Psychiatrists were doing some of the most effective work at clearing stations right near the front line, commission members reported.

NOW AVAILABLE

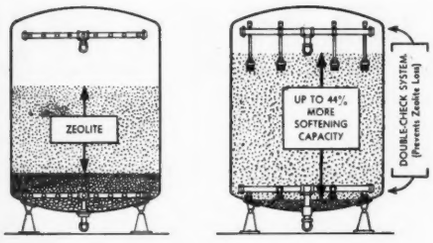
postwar design

ELGIN WATER SOFTENER



. . . delivers up to 44% more soft water

NOTE THE INCREASED CAPACITY



ORDINARY WATER SOFTENER DESIGN

ELGIN WATER SOFTENER DESIGN

HERE'S HOW TO STEP UP THE OUTPUT OF YOUR PRESENT WATER SOFTENER

The "Double-Check" equipment can be installed in place of the present manifold in your zeolite softener regardless of make. This change, along with Elgin High Capacity Zeolite, will give you greatly increased soft water output. The cost of this modernization is surprisingly low. Let us give you facts.

• Here's real news for users of zeolite water softener equipment. Our postwar design is now available. It delivers up to 44% more soft water than any other unit of equal size. Of importance is the fact that this new water softener has been fully proved by gratifying results in a long list of plants where it is already in service.

An improved double-check type manifold prevents the escape of zeolite and therefore permits placing a far greater amount of water softening zeolite in the softener, as shown. More zeolite means more soft water output—for it's the zeolite that does the softening.

But that isn't all. A higher backwashing rate is also made possible by preventing loss of zeolite. This higher rate cleans the softener thoroughly. With the zeolite bed clean, the salt reaches every grain of zeolite. The result is better regeneration with less salt consumption . . . higher over-all efficiency.

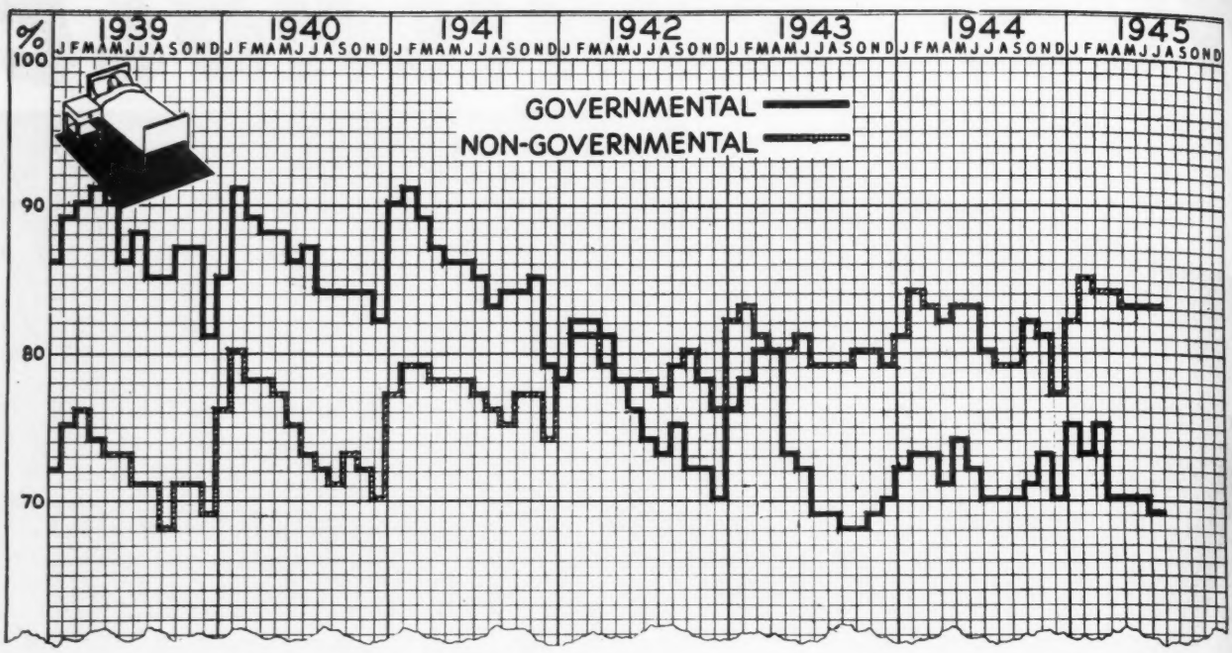
The whole story of tomorrow's water softener today is told in brand new bulletin 606. Write for your copy today.

ELGIN

The complete Elgin line—Boiler Water Treating and Purifying Systems • Feedwater Treatment • Deconcentrators • Heat Exchangers • Water Softeners • Filters and Purifiers • Iron Removal Equipment • Aerators • Water Treating Chemicals • Chemical Feeders • Scale and Corrosion Inhibitors • Sample Coolers • Water Testing Equipment • Zeolites

ELGIN SOFTENER CORPORATION, 144 NORTH GROVE AVENUE, ELGIN, ILLINOIS

Occupancy in Voluntary Hospitals Still High



Occupancy in the nongovernmental general hospitals continued at 83 per cent, the same high level achieved during 1944. In governmental general hospitals, however, it dropped a point to reach 69 per cent.

Another large total of new construction projects was reported during the period from July 23 to August 20. There were 46 new projects, with 37 giving costs of $14,899,000. This brought the total reported since last January 1 to $169,804,000, as compared with $67,150,000 for the same period of last year. During the most recent reporting period there were 13 new hospitals, of which 10 were to cost $4,225,000. There were 32 additions, of which 24 gave costs of $8,295,000. One nurses' home is to cost $250,000. Late reports accounted for the rest.

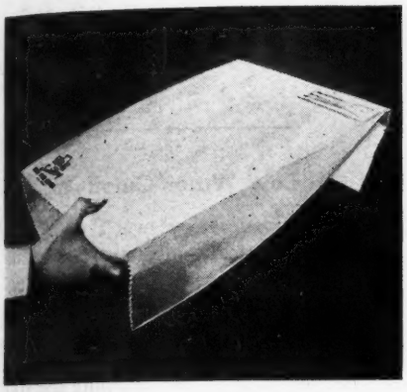
What's New for Hospitals

SEPTEMBER 1945 SUPPLEMENT TO THE MODERN HOSPITAL

Sanitary Bedpan Cover

A disposable, paper bedpan cover has been announced by the Surgeon's Division of the American Safety Razor Corporation. This new cover, which is well designed and will fit all standard bedpans, provides a sanitary safeguard against danger of cross infection.

Easily fitted over the bedpan, this tough paper cover has almost an en-



velope effect, covering the pan on top, both sides and part of the bottom. Its odor-sealing effect will be appreciated by the patient and the nursing personnel as well as by those responsible for keeping unpleasant odors at a minimum. In addition it cuts laundry costs. **(Key No. 2825)**

American Safety Razor Corp., Dept. MH, 315 Jay St., Brooklyn 1, N. Y.

Femur Plate

A new heavy duty femur plate has been developed by DePuy Manufacturing Company. Made of 18-8 stainless molybdenum steel, the plate has a series of holes for anchoring to the bone and a slot which accommodates any absorption and eliminates pull on screws and buckling of the plate. The new plate is available in three sizes, 4, 5 and 6 inches long. **(Key No. 2787)**

DePuy Mfg. Co., Dept. MH, Warsaw, Ind.

Hearing Aid

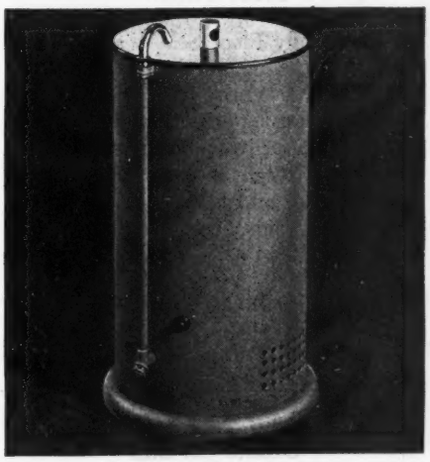
A new light weight, small size hearing aid has recently been announced by Western Electric Company. Designed by Bell Telephone Laboratories, the new device weighs approximately 6 ounces and has two sensitive fingertip controls which permit selection of volume and tuning out of background sounds. Known as Model 63, the hearing aid provides full amplification through three miniature electron tubes which are quickly replaced without soldering. **(Key No. 2777)**

Western Electric Co., Dept. MH, 195 Broadway, New York 7

Therapeutic Bath

Impeller action to distribute whirling, aerated water evenly throughout the unit is a feature of the improved type circulating therapeutic bath announced by General Electric X-Ray Corporation. A compact, streamlined device known as the Rocke Hydrotherapy Bath, the unit provides a steady, even circulation of water in a direction conforming to the vertical position of the limbs. The vigor of the action can be increased or decreased by a conveniently located valve.

The effect of the treatment simulates manual massage while the heat increases



peripheral circulation. The unit is mobile and self contained, requiring no plumbing connection. It is 34 inches high and employs a ¼ h.p. motor which also operates the drain pump. The tank is porcelain enameled steel supported on four ball bearing casters. **(Key No. 2773)**

General Electric X-Ray Corp., Dept. MH, 2012 W. Jackson Blvd., Chicago 12

Mobile Cafeteria

The AerVoid Mobile Cafeteria has been developed for the distribution of hot foods in quantity. Vacuum insulated food carriers are assembled in a mobile unit especially developed for this purpose and food remains hot until it is ready to be served in the floor kitchens or

wards. Each carrier can be used for one hot dish or, with a pan assembly, can carry up to five different hot foods. The unit contains four carriers, each of which is sealed against contamination by a tight closing, gasket fitted cover.

The carriers operate on the principle of slowly retarding loss of heat because of their high vacuum insulation. They are of sturdy construction and have no electrical connections and no breakable accessories. **(Key No. 2788)**

Vacuum Can Co., Dept. MH, 19 S. Hoyne Ave., Chicago 12

Instant Starting Fluorescent Lamp

A new 40 watt instant starting fluorescent lamp has been designed with special attention to elimination of operating faults frequently found in areas having high humidity. The lamps have a special hydrophobic coating which cannot be rubbed or scratched off and which prevents the formation of a film of moisture. They are designed to operate in a two lamp compensated ballast circuit providing 450 volt operation. **(Key No. 2791)**

Sylvania Electric Products, Inc., Dept. MH, Salem, Mass.

Address manufacturers for further information and prices—or use Readers' Service blank on page 300

Bedside Lamp

The improved No. 100 utility bedside lamp recently introduced by Eichenlaubs has an adjustable shade that can be swung to a full upright vertical position from either right or left. The automatic tension of a helical spring holds the shade at any desired position.

Other features of the lamp include a night light below mattress level, conveniently located outlet on head assembly for plugging in radio, heating pad and other electrical accessories with the lamp switch independent of this outlet and a ventilated, metal barrel shade with washable reflector. **(Key No. 2785)**

Eichenlaubs, Dept. MH, 3501 Butler St., Pittsburgh 1, Pa.

American Woostershire Sauce

John Sexton and Company has developed American Woostershire Sauce as an addition to the line of Sexton Sauces. Blended of malt vinegar, lime juice and spices and aged in wood, this new sauce will be a welcome addition to the dietitian's flavor favorites. It is available in 6 ounce bottles for individual use and in gallon jugs for institutional cooking requirements. **(Key No. 2790)**

John Sexton & Co., Dept. MH, P.O. Box J.S., Chicago 90

Alnico Magnet

Use of a magnet for the removal of metal objects from the alimentary canal has proved successful with the specially designed Alnico magnet developed by the General Electric research laboratory. Inserted down a bronchoscope tube, the magnet contacts the metal object with the help of fluoroscopy and makes possible its quick removal.

The Alnico magnet has exceptional strength and is less subject to demagnetization than other materials. Containing aluminum, nickel, cobalt and iron, Alnico is so hard that it must be cast to desired shapes. **(Key No. 2778)**

General Electric Co., Dept. MH, Schenectady, N. Y.

Oxygen Chamber

The Continentalaire iceless oxygen and air therapy chamber has been streamlined and modernized. With completely automatic control of temperature and humidity in oxygen and air administration, the unit operates at a prescribed temperature with one setting of the control lever. The freonized air conditioning unit cools the air to the temperature prescribed and the air passes through a film of moisture, thus removing airborne irritants. The cost of operation is small and the unit requires practically no attention during operation. **(Key No. 2789)**

Continental Hospital Service, Inc., Dept. MH, 18636 Detroit Ave., Cleveland 7, Ohio

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Electric Heater Repair

A powder flux for repairing electrical heating elements has been developed by Chanite Sales Company. When the wire in the heating element or electric device is burned in two or broken, it can be quickly and easily repaired by applying a small amount of Chanite Flux. The product is inexpensive and effective for repairs of this type. **(Key No. 2697)**

Chanite Sales Co., Dept. MH, 914 S. Main St., Ft. Worth 4, Tex.

Floor Finish

Heavy Duty Floor Seal is a new floor finish for use where floors receive unusually hard wear. The product has good penetrative power and is waterproof. It is easily applied and dries in one hour. It can be used on any type of wood floor and is available in drums, five gallon cans, gallons and quarts. **(Key No. 2686)**

O'Brien Varnish Co., Dept. MH, South Bend 21, Ind.

Oakite Tri-San

A new sanitation development which kills odors, disinfects and cleans in the same operation is now available in Oakite Tri-San. A mildly alkaline, free flowing, white powder, completely soluble in water, Tri-San has germicidal and fungistatic action on various bacteria and mold organisms. It is used as any other cleaning material, dissolved in water and mopped or brushed on the surface to be cleaned. However, where odor control is the specific problem, Oakite Tri-San may be sprayed directly on the surface. **(Key No. 2795)**

Oakite Products, Inc., Dept. MH, 22 Thames St., New York 6

NoDrip Tape

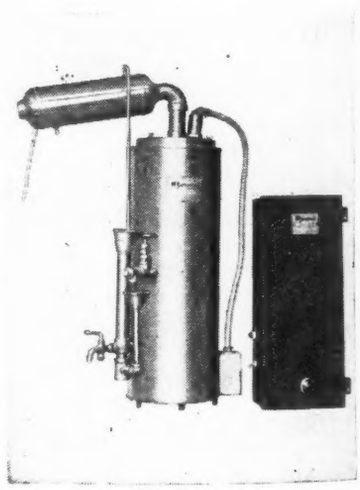
NoDrip Tape is a pliable, cork-filled tape designed to stop damaging drip from cold water pipes. The tape forms a snug, sealed jacket around pipes and is quickly and easily applied without special tools or experience. The tape is made only in brown but can be painted and requires no maintenance. **(Key No. 2692)**

J. W. Mortell Co., Dept. MH, Kankakee, Ill.

Low Water Cutoff

A new floatless low water cutoff for users of electrically heated water stills has been developed to shut off the electricity automatically if the water level in the evaporator drops below the proper operating level. The remote control cabinet for starting and stopping the still and resetting the cutoff is an important feature since it can be mounted in any convenient place regardless of the location of the water still.

The cutoff operates on a weak current flowing through an electrode rod into the water in the evaporator and requires no maintenance. The remote control cabinet has a pilot light to indicate when



the still is running. A floatless cutoff is also available for gas heated stills. **(Key No. 2786)**

Barnstead Still & Sterilizer Co., Inc., Dept. MH, 5 Lanesville Terrace, Boston 31, Mass.

Address manufacturers for further information and prices—or use Readers' Service blank on page 300

PHARMACEUTICALS

Delacillin

Delacillin is a sterile suspension of penicillin calcium in peanut oil and 4.8 per cent bleached beeswax which prolongs the period over which the therapeutic effect of penicillin is maintained by its slow absorption following intramuscular injection. It is designed preferably for intramuscular administration, may be used subcutaneously but never intravenously. Because elimination is slowed considerably, it is said that a single daily injection of Delacillin will provide the full desired therapeutic effect. **(Key No. 2799)**

E. R. Squibb & Sons, Dept. MH, 745 Fifth Ave., New York 22

Measles Serum

The gamma globulin fraction of the normal adult plasma, Immune Serum Globulin-Human, is now available for civilian use. Highly potent in active specific antibodies, the product provides modification or complete protection against measles. It has been available to the armed forces and the Red Cross and results indicate that intramuscular injection is practically painless and general reactions are rare. The product is supplied in 2 cc. rubber stoppered vials. **(Key No. 2800)**

Cutter Laboratories, Dept. MH, P.O. Box 245, Berkeley 1, Calif.

Albumintest

A simple, reliable, qualitative test for albumen has been developed by the Ames Company. No heating is required and either the contact ring or the turbidity method may be used. Known as Albumintest, the reagent, which is nonpoisonous and noncorrosive, is made as needed by adding one reagent tablet to 4 cc. of water. The tablets come in bottles of 36 and 100. **(Key No. 2779)**

Ames Co., Inc., Dept. MH, Elkhart, Ind.

Dayamin Liquid

A pleasant tasting, homogenized mixture, Dayamin Liquid provides a nutritional supplement for the treatment of multiple vitamin deficiencies. Each teaspoonful supplies the recommended daily allowances for vitamins A, D, B_1, C, riboflavin and nicotinamide. Its pleasant flavor recommends it for administration to children and adults who prefer a liquid preparation to capsules and it can be mixed with food if desired. Dayamin Liquid is supplied in 90 cc. bottles. **(Key No. 2582)**

Abbott Laboratories, Dept. MH, North Chicago, Ill.

Mesopin

Mesopin tablets, each containing 2.5 mg. of Mesopin, the mandelic acid ester of tropine methyl bromide, have been announced as a gastrointestinal antispasmodic, without undesirable side effects or toxicity.

Also but recently announced is Mesopin With Phenobarbital, each tablet containing, in addition to 2.5 mg. of Mesopin, 20 mg. of phenobarbital. This product is indicated where it is desirable to supplement the musculatropic action with a sedative. Both tablets are available in boxes of 20, 100, 500 and 1000. **(Key No. 2627)**

Endo Products Inc., Dept. MH, 84-40 101st St., Richmond Hill 18, N. Y.

"pHisoderm"

A synthetic, sudsing and emollient detergent cream, "pHisoderm" is the result of extensive clinical and laboratory study in the development of a prescription item for the cleansing of skin which is sensitive to soap. The product is active in any kind of water and is available in two types, regular for average skin and oily for individuals whose skin is unusually dry. Containing no soap, fatty acids, alkali or coloring matter, "pHisoderm" is hypo-allergenic and has a stable pH of 5.5. **(Key No. 2661)**

Fairchild Brothers & Foster, Dept. MH, 76 Laight St., New York 13

Dee-Osterol

Dee-Osterol is a vitamin D_2 product designed for infant feeding and for use during pregnancy and lactation in cases requiring increased intestinal absorption of calcium and phosphorus if comparatively large doses of vitamin D are desired. It is provided in capsule form for oral administration, each Dee-Osterol-cap containing activated ergosterol providing vitamin D_2, 50,000 U.S.P. units. It is also provided in 30 cc. rubber capped vials, each containing 50,000 U.S.P. units of vitamin D_2 per cc. in oil with chlorobutanol 3 per cent as a local analgesic for intramuscular injection. **(Key No. 2657)**

George A. Breon & Co., Dept. MH, Kansas City 10, Mo.

RECENT CATALOGS AND BOOKLETS

• Recipes for making rich meat base soups in a minimum of time, and without soup bones, are contained in a new booklet, **"B-V Meat Magic,"** offered by Wilson & Co., Inc., 4100 S. Ashland Ave., Chicago 9. B-V recipe cards printed on heavy 4 by 6 inch stock and featuring 6, 25 and 100 servings with approximate costs included are also available. **(Key No. 2805)**

• Pharmacists will be interested in a **Prescription Record Form** which has been prepared by Owens-Illinois Glass Co., Toledo, Ohio. An accurate and complete record of daily prescription sales can be kept on these forms which are available without charge. **(Key No. 2818)**

• Hospital administrators and those concerned particularly with occupational therapy and related problems will find much helpful information in a new booklet entitled **"Curing by Printing"** which has recently been issued by American Type Founders Sales Corp., Elizabeth B, New Jersey. The booklet is a result of long study of the values of printing activities in occupational therapy and, together with the specification folders also available, provides practical information which should prove of value in planning and operating an occupational therapy department. **(Key No. 2809)**

• **"Roach Repellent Cement"** is the title of a reprint by Frank O. Hazard which describes and explains this particular quality of "Hubbellite," a novel cement incorporating finely divided copper powder in magnesium oxychloride cement. The article contains charts showing the repellency effect of Hubbellite on various types of roaches and has been made available by H. H. Robertson Co., Farmers Bank Bldg., Pittsburgh 22, Pa. **(Key No. 2769)**

• The complete line of heavy-duty destructors and Kernerator **incinerators** now available from the Morse Boulger Destructor Co., 205 E. 42nd St., New York 17, is described in a bulletin recently received. The various types of incinerators are described and illustrated with standard layouts and sketches showing types for hospitals of different sizes. **(Key No. 2666)**

• **"Horn Maintenex,"** designed for easy cleaning of areas such as entrance lobbies, receiving rooms and similar locations where there is heavy traffic, is described in a folder prepared by A. C. Horn Co., 43-36 Tenth St., Long Island City 1, N. Y. **(Key No. 2768)**

Address manufacturers for further information and prices—or use Readers' Service blank on page 300

• A Research Bulletin on **"Washroom Supplies"** has recently been released by Troy Laundry Machinery Div., American Machine and Metals, Inc., East Moline, Ill. The studies include discussion of water, soap, alkalis, bleaches, blues and sours and contain several charts. **(Key No. 2762)**

• Five types of all metal compartments for postwar installation are described in a 16 page booklet issued by Sanymetal Products Co., Inc., 1705 Urbana Rd., Cleveland 12, Ohio, entitled **"Toilet Compartments." (Key No. 2724).**

• **"Instant Heat Soldering Tools"** manufactured by Ideal Commutator Dresser Co., Sycamore, Ill., are illustrated and described in a catalog-type leaflet which should be of interest to the maintenance department of the hospital. **(Key No. 2726)**

• A digest of thirteen recently published papers on the employment of Premarin has been assembled in a booklet entitled **"Estrogens in Clinical Practice"** and published by Ayerst, McKenna & Harrison, Ltd., Rouses Point, N. Y. **(Key No. 2723)**

• **"Step Inside and Meet the Vegex Family"** is the inviting title of a pamphlet prepared by the Vegex Co., 175 Fifth Ave., New York 10. Instead of the usual formal descriptive material, this pamphlet has cartoon type illustrations of Alex the Vegex Cook who, supposedly, has prepared the text which gives helpful information on Vegex flavoring, together with recipes, in an interesting, conversational style. **(Key No. 2814)**

• Full descriptive information on **"Sanitary Engineered Kettles and Coffee Urns"** made by Royce L. Parker, Inc., Bellwood, Ill., is presented in a pamphlet recently prepared. Included in the helpful information are twelve points to consider in selecting this type of equipment. **(Key No. 2631)**

• A new food chart showing by text and illustration **"The Foods You Need Every Day"** has been prepared by the National Live Stock and Meat Board, 407 S. Dearborn St., Chicago 5. **(Key No. 2727)**

• **"Bibliography on Oxygen Therapy"** (Supplement No. 2), listing articles in domestic and foreign medical literature relative to the use or lack of oxygen in medical care, has been prepared by Linde Air Products Co., 30 E. 42nd St., New York 17. **(Key No. 2757)**

• The administrator and his department head concerned with pumps will be interested in two bulletins recently released by Fairbanks, Morse & Co., Pomona, Calif. **Publication AQB400.1** describes the Fairbanks-Morse Figure 6910 Oil Lubricated Turbine Pump and the large capacity line of pumps known as Fairbanks-Morse Niagara Propeller Pumps is described in **Publication AQB500.1. (Key No. 2758)**

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Manufacturers' Plant News

American Optical Company, Scientific Instrument Division, is the new name for the Spencer Lens Company, Buffalo 11, N. Y. The change became effective June 30 although the Spencer Lens company was purchased by the American Optical Company in 1935. The company reports increased manufacturing facilities and an enlarged scientific staff. **(Key No. 2823)**

Removal of the executive, sales, merchandise and pricing departments of the **Systems Division of Remington Rand, Inc.,** from Buffalo, N. Y., to new offices located in the Remington Rand Bldg., 315 Fourth Ave., New York 10, has been announced by Mr. Al N. Seares, Vice President and General Manager of this division. **(Key No. 2824)**